ANGLIA RUSKIN UNIVERSITY

THE SPIRITUALITY OF CAREGIVING: WITH REFERENCE TO CLINICAL PASTORAL TRAINING IN HONG KONG

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A thesis in partial fulfilment of the requirements of
Anglia Ruskin University for the degree of
Professional Doctorate in Practical Theology

This research programme was carried out whilst
Enrolled as a student with the Cambridge
Theological Federation

Submitted: September 2017

ANGLIA RUSKIN UNIVERSITY
ABSTRACT

FACULTY OF ARTS, LAW AND SOCIAL SCIENCES

PROFESSIONAL DOCTORATE

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SEPTEMBER 2017

The context for this study is the researcher's professional context as a supervisor of Clinical Pastoral Care Training (CPT) for Hong Kong spiritual caregivers. The purpose of the study is to enhance the researcher's professional practice by exploring the understanding of spirituality held by Hong Kong Chinese spiritual caregivers and the kinds of influences that might have shaped their understanding and practice.

My professional interaction with trainees as a CPT supervisor revealed a confused understanding of spirituality among Hong Kong Chinese spiritual caregivers, and resulting difficulties in their practice in the local healthcare services. Engagement with the literature in four contexts: spirituality in the healthcare service, in Christianity, in CPT, and in Hong Kong Chinese culture, highlighted confusion within each context and conflict between the different influences. In light of this conceptual framework, qualitative interviews were conducted with three chaplains and three registered nurses to uncover the understanding of spirituality held by Hong Kong Chinese spiritual caregivers and the kinds of influences that might have shaped their understanding and practice. The aim was to explore their experiences in caregiving and CPT so that future training might better address the needs of Hong Kong Chinese spiritual caregivers.

The dynamics between the four shaping influences—the healthcare system, Christianity, CPT and cultural factors—were important in shaping the participants' understanding and practice and also led to identity confusion. Within this complex set of relations, four related concepts were drawn out in connection with the meaning of spirituality. Spirituality was found to be about the person, about God, about relationships, and about love.

The identification of these four diffused concepts of spirituality and the analysis of the dynamics between the four different influences affecting spiritual caregivers' understanding is the contribution this study makes to knowledge. The research process enhanced the researcher's intellectual and professional understanding of a certain confusion about spirituality in the Hong Kong healthcare context. A modest change to practice is recommended, so that CPT may address this confusion that is evident among Hong Kong Chinese health caregivers.

Key words: spirituality, Christianity, Clinical Pastoral Training, Hong Kong Chinese culture

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A Personal Narrative

Introduction

It is nearly a century since the Clinical Pastoral movement began in the United States. Because Clinical Pastoral Training (CPT) was introduced to Hong Kong from the U.S., the local picture has been mixed and contradictory. On the one hand, there has been an increase in the number of training centers, professional chaplaincy has been established, and persons from other religious backgrounds have started to join CPT. The importance of spiritual care has thus been recognized in the Hong Kong healthcare context. On the other hand, there is an inchoate sense that the training lacks direction. The role and task of CPT as either theological education or training, as either for Christians or for people of other religious faiths, and as either just for pastors or for other health caregivers also, is not clear.

This research thesis is an exploration of the spirituality of caregiving with special reference to Clinical Pastoral Training in Hong Kong. It is about the dynamics between the healthcare system, Christianity, Clinical Pastoral Training (CPT) and Hong Kong's Chinese culture. This framework comes from a review of the concept of spirituality in the literature from the above contexts, and from my phenomenological reflections as a registered nurse, a chaplain and a CPT supervisor of Hong Kong. It is a piece of empirical research focusing on the perspectives on spirituality of six Hong Kong Christian spiritual caregivers, their caregiving practice, and their experiences in training. The systems, beliefs and values behind their understanding are different from those of the western context. This research is faith seeking understanding about spirituality and the interplay between different shaping influences, i.e., the healthcare system, Christianity, CPT and cultural factors. The goal is to inform my knowledge and in turn enhance my professional practice as a CPT supervisor in addressing the needs of spiritual caregivers.

This opening chapter is my own narrative. It is about my phenomenological world as a nurse, a chaplain and a supervisor of Clinical Pastoral Training. I will show how my own

narrative relates to the research that I have conducted. An overview of chapters is then provided, which lays out the structure of the thesis and explains how the different parts are interconnected as a whole.

1.1 Frustration of a Nurse Providing Religious Spiritual Care

I became a registered nurse in the 1980s at an acute-care hospital in Hong Kong after a three-year training program organized by the Queen Elizabeth Hospital, Hong Kong. At that time, nursing training was still hospital-based and we were employees of the Hong Kong government. Before I entered training, I sought advice from my church pastors and elders. They all agreed that nursing was meaningful, as I could study and work, and care and evangelize at the same time. They all said that I was gentle and would be a good Christian nurse. With their blessing, I chose to become a nurse. After the first year of training, I decided to be baptized and became a member of the church as a "formal" Christian. This decision of an eighteen-year old girl meant something: I wanted to care for and serve patients as a good Christian. I believed that the greatest mission of caring was to lead patients to Christ, who promises rich and abundant life after death.

I joined the hospital Christian Fellowship and became an active member, learning from the seniors how to organize different kinds of gospel work in the hospital. At that time, there was no chaplain serving in the hospital. Christian nurses were the main professional volunteers providing religious spiritual care in any organized way. We would follow up with patients who committed themselves to Christ at the gospel meetings. As we were members of the healthcare team, we could easily visit patients when we were off duty. At that time, I was responsible for working with children in the pediatric units. I organized various activities, such as storytelling, game time, magic shows and arts and crafts. I was amazed that every time I asked them whether they would like to accept Jesus in their hearts, 99.9 percent of children would say yes. I can still remember how their eyes shone and how sweet their smiles were. Sometimes I wondered how much they understood about the real meaning of salvation, however. I was often puzzled about what it meant for them to accept Jesus. It seemed to be only entrance permission into heaven, at a time and place nobody knew. I was in pain when I saw them suffering. Apart from their physical

pain, there was emotional pain also: because they were being cared for in the hospital, and they could only see their parents once a day for two hours. Some were even born with cancer. They were living, yet they did not know that they were going to die. I felt helpless as they could not understand the meaning of salvation. The love promised by the gospel could not soothe the little suffering faces I saw day after day. Salvation could neither ease their pain nor relieve my burden as a young nurse. There was thus conflict between my religious world and the strange new world of healthcare.

In addition to the conflict between my two worlds, there was also conflict within my core, in terms of my Christian spiritual life. There was frustration within my heart. At that time, I wanted to be a good Christian nurse. After baptism, I became a member of the church and was formally a Christian. I had to live out the mission of a good Christian. Unconsciously, I wanted to fulfill the expectations of my pastors and elders. However, as a nurse on shift duties, I could not attend regular Sunday services or the Saturday fellowship. I did not have a stable church life and often had to leave my friends in the middle of gatherings. Although some of them seemed to understand and accept my reasons, I felt bad. Gradually, I stopped wanting to go to Church, even when my duties permitted. I found that my brothers and sisters did not really understand the struggles of my "new life". Gradually, the needs of evangelism in the hospital became my focus. I had more and more jobs and titles in the fellowship. My life was fully packed with work, study and service. There was a disjunction in my life between providing religious spiritual care and self-care.

There were responsibilities to fulfill in order to be a good Christian nurse. I felt that I had to do a lot in order to reach a good standard. Without knowing when it started, the love of God seemed to be bound with conditions. When I was on duty, I did not allow myself to stop, even on less busy days. I drove myself to share with patients, as a good Christian nurse should do. After getting off from a hard day at work, I drove myself to "follow up" with patients. I thought that maybe I could save just one more before death came to them. Yet no matter how much I did, the pain in life was too much and too heavy to be taken away. Moreover, I felt guilty for not attending church. I condemned myself when I was too tired to do the follow-up work and to share. Gradually, the passion to be a good

Christian nurse was gone. There was only frustration and failure left. The blessings of the gospel became meaningless and were a burden in my daily life. There was no hope and no possibility of goodness in life. Though I still remained in the volunteer service, there was no more excitement in my heart, even when my hands were showing their commitment to Christ. At that time, there was only tiredness and frustration. I did not know and was not willing to accept my own limitations. I blamed myself for not being good enough as a Christian nurse. This vicious circle went round and round. The core of my life, Christianity, was in conflict within me.

Life was frustrating because of the disjuncture in my life between the two different worlds of religion and healthcare. I persuaded myself to complete the training and get the professional certificate before leaving. Then, for practical reasons, I remained in the profession after I graduated from nursing school. I successfully became a healthcare professional who was also the authority on health in my Chinese family.

At that time, my mother, as with many Hong Kong Chinese families, would prepare different types of Chinese herbal teas according to the different seasons in order to enhance health. My family members would go to see the *die da*, or bonesetter, for any injury or fall. I was the only one in the family to escape those bitter herbal teas. I would even seek to educate them not to adhere to the myths of Chinese medicine by sharing my clinical experiences with them. In those days, the hospital often admitted patients suffering from misuse of Chinese herbs, self-medicated Chinese drugs, and allergies from the application of herbal bandages. As a kind of health education, we would tell them to stop their traditional health practices, which were outdated. We would educate them on the new and updated concepts about health. If cancer patients were found to have taken ashes given by some religious person, they would be reprimanded by our team of healthcare professionals.

There was a wedge between the Chinese concepts of health and western medicine. The conflict between east and west was manifested in my family between my mother and I. After I gave birth to my first daughter, my mother was very caring and came over to my home to look after my health. She accompanied me for the first two months, which was considered the most important period for restoring health in the post-partum period.

According to Chinese culture, this period was about maintaining a healthy, but different, style of living. I had to eat, bathe and even wash my hair with ginger. I had to avoid washing my hands or being exposed to any kinds of "wind" that might cause life-long harm. I had to drink ginger and vinegar soup to enhance circulation. As a healthcare professional, all this seemed crazy to me, especially as I had a normal delivery and my daughter was born in the hot summer. I remembered that I did not follow my mother's ideas and had arguments with her. I even reminded her that as Christians, we should avoid traditions that had been mixed with other religious beliefs and were not scientific. Supported by my husband, who was also a healthcare professional, I thought I was holding on to the truth. The health concepts in these traditions were not evidence-based and were outdated. Today I realize that there was a conflict between my western healthcare world and the Chinese cultural world. Though I was not aware of it at the time, the conflict caused a tension in my relationship with my family. As a daughter, I felt sorry for hurting my mother. I was rejecting her kind loving care, which she was simply expressing as part of Chinese culture.

There was conflict between my religious world and the healthcare world. There was also conflict in my spiritual life in Christianity, which was further complicated by the differences between the western concepts of health and my Chinese culture.

1.2 Confusion of a Chaplain Providing Holistic Religious Care

Despite my frustrations in trying to be a good Christian nurse, I remained in the profession on and off for more than twenty years. I only formally left the profession when I started studying for my Bachelor of Theology. By that time, I was a mother of three children. I took Clinical Pastoral Training (CPT), in my seminary, which regarded the training as part of pastoral theological education. After finishing my theological studies, I joined the chaplaincy at one of the two medical teaching hospitals in Hong Kong. I provided spiritual care to patients as well as pastoral care to healthcare professionals. In the third year of my service, the North-East Cluster, including Prince of Wales Hospital where I was working, became the first cluster to change the role of a chaplain. Chaplaincy became a formal service provided under the allied healthcare department.

Instead of being a volunteer in the hospital, chaplains became honorary staff. With this recognition, chaplains became healthcare professionals who had to abide by all the rules of the hospitals.

Having been away from the healthcare service for many years, I found a great change when I re-entered the field. Religious persons were accepted and included in the service. The importance of spirituality was fully and formally recognized. Yet I found that patients who were referred to us by the healthcare professionals were mainly those suffering from emotional problems. Patients who cried and expressed suicidal thoughts would most definitely be referred to meet with chaplains. At the same time, chaplains did not routinely do ward rounds in the psychiatric units of the hospital as they did in general wards. Chaplains were excluded from the care of emotionally upset patients in psychiatric units. There was thus a gap between recognition of the importance of spirituality and the actual practice of spiritual care.

At the time I re-joined the healthcare sector as a chaplain, I had finished my theological studies and two units of Clinical Pastoral Training. I thought that I now had a slightly better understanding of spirituality in Christianity and pastoral care. However, I became confused about my identity as a holistic health-spiritual caregiver and as a religious-spiritual caregiver. Patients asked me repeatedly about the meaning of spiritual care. I found that my understanding of spirituality from a religious perspective was not adequate in answering their questions. Every healthcare professional was talking about spirituality, yet no one seemed able to explain what spirituality was. I wanted to find out more about spirituality from the healthcare literature. I thought that if I could find a common language of spirituality from that context, I could communicate better with different kinds of persons in the hospital. There would be less confusion.

Prompted by this curiosity, I joined a Master's program in behavioral health at Hong Kong University. I was part of the first batch of students of the program. It was especially designed for healthcare professionals. My classmates included a nurse, doctor, social worker and therapist. I was the only chaplain. The program was about health and healthcare under a framework of holism with an emphasis on spirituality. At the graduation party, we tried to "sum up" what we had learned about spirituality after two

years of study. I found that spirituality was a term still loosely used and defined. It was given a one-size-fits-all description under a wide spectrum of definitions. As a result, we all found that spirituality remained mysterious and confusing.

Taking with me an increased understanding of spirituality from the literature, which I characterized as a one-size-fits-all description under a wide spectrum of definitions, I found that I had nevertheless become a bit more at ease with my identity. I had widened my perspective and no longer limited my understanding of spirituality to the framework of religion. According to my observations, there was a common understanding of spirituality in the healthcare service, which was expressed as “holism”. Everyone agreed that the physio-psycho-social and spiritual dimensions were important in holistic health. This became the biggest common denominator for health caregiving. However, in my spiritual care experience, no matter how wide the spectrum encompassing spirituality, the presence and movement of the Holy Spirit was so specific to an individual that the common denominator in the definitions could not adequately describe it. It was real, but mysterious. It could not be explained or “objectively” identified. It was in my patients’ lives, within myself as a person and in the encounters between two human beings. I was eager to find out more.

As a chaplain caregiver providing holistic religious spiritual care, I enthusiastically tried to integrate the world of literature with the phenomenological world. I continued to find that there was gap between these two worlds, which I was eager to understand.

1.3 Knowledge Gap of a Clinical Pastoral Training Supervisor

While completing the second advanced CPT unit during my chaplaincy service, my supervisor invited me to join supervisory training in the seminary. I left the chaplaincy and finished supervisory training full-time in three years. As a certified CPT supervisor in a seminary, I worked closely with trainees from different backgrounds. There were pastors, healthcare personnel, therapists and final-year students from different programs of the seminary. However, regardless of how rich their previous lives and work experiences were, most of them would become very anxious in CPT. Once they entered

the healthcare service, they experienced a lot of confusion on the boundaries between the healthcare system, the religious tradition and the CPT influence. On the one hand, they wanted to do evangelism as a Christian should. On the other, they were instructed that as spiritual caregivers in the hospital, they had to respect patients' choices and care for their needs. Moreover, although they served in the role of "spiritual caregiver trainees", they would experience helplessness in caring for patients with different kinds of life suffering and questions. Yet they persevered in their training and experienced growth. Their perspectives in the aforementioned areas widened and were reshaped, which they found very helpful for themselves and for their caregiving. I found I shared my trainees' frustrations and confusion along the journey. I witnessed their changes as a third-person observer. Some of their anxieties and reactions seem to run parallel with those I had experienced. The conflict was now clearly manifested and amplified before me. I was curious to find out about their experiences of spirituality and the kinds of shaping influences that might affect their understanding and practice.

In my supervisory training of spiritual caregivers, I reflected that both CPT and healthcare concepts had originated from western culture and migrated to Hong Kong. There was thus a research gap in how the local language and culture might affect the understanding of the spirituality of caregivers in the Hong Kong healthcare context. I wanted to discover how spirituality had been indigenized in the Hong Kong Chinese healthcare context. The first research question is therefore, "What understanding of spirituality is held by Hong Kong Chinese spiritual caregivers with reference to Clinical Pastoral Training (CPT)?" Behind this question is the presupposition that any understanding is affected by culture, of which language is a key factor. Moreover, we do not know how the culture interacts with other influences, including the healthcare system, Christianity and CPT. The second research question is therefore: "What kinds of influences might have shaped the understanding of spirituality and the practice of the caregiver?" These shaping influences or forces may have existed and developed over a long period and their effect can be subtle, implicit, and people may be unaware of them. In asking this research question, there is a presupposition that the influences of different forces will vary according to the caregivers' different backgrounds. For the research, I therefore looked at the perspectives of a group of nurses and a group of chaplains. These

are the two main groups of professionals providing spiritual care in Hong Kong. This empirical research was designed to help me understand how the different shaping influences interact.

So what is the purpose of understanding the above? This question concerns the contribution of my research to practice, and leads into my third research question: "How might Clinical Pastoral Training address the needs of the spiritual caregiver?" I am working on the presupposition that spiritual caregivers face a lot of frustration and confusion on the boundaries between the different influences in the caregiving service. The understandings and insights gained from the research are designed to help me and other Hong Kong Chinese Clinical Pastoral Training supervisors improve the training process. I also hope that this local empirical research can suggest directions in the development of Hong Kong CPT, which faces the challenges of the coming century, including moving from serving Christians only to serving multi-faith caregivers, and moving beyond theological education to spiritual care training.

1.4 Overview of Chapters

In order to answer the research questions, I have set out my thesis in three sections. The first section comprises four chapters of theoretical perspectives on spirituality and caregiving: the healthcare context (chapter 2); Christianity (chapter 3); Clinical Pastoral Training (chapter 4); and Hong Kong Chinese culture (chapter 5). This framework comes from a review of the concept of spirituality found in the literature of these different worlds, and from my own phenomenological world as a registered nurse, a chaplain, and a clinical pastoral supervisor in Hong Kong.

The second section details the empirical research. It comprises three chapters, which include the research design and methodology (chapter 6) and the discussion of data (chapters 7 and 8). This section seeks to fill knowledge gaps about spirituality in Hong Kong healthcare through fieldwork. The third section has three further chapters that relate my fieldwork to the literature, outline recommendations for professional practice and reach a conclusion. Chapter 9 answers the research questions, i.e., the understanding of

spirituality of Hong Kong Chinese spiritual caregivers, the different influences that might shape their understanding and practice and the ways that Hong Kong Clinical Pastoral Training might address the needs of spiritual caregivers. Chapter 10 is the conclusion. I consider that in the understanding of spirituality and caregiving, the different contexts (the healthcare context, Christianity, Clinical Pastoral Training and culture) are interconnected and interdependent. If any one of the contexts is not connected to the whole, understanding becomes unstable and the practice unhealthy.

Section I: Theoretical Perspectives

Chapter 2 : Spirituality in the Healthcare Context

There is extensive research on spirituality in the healthcare literature. It centers on understanding and caring for a person in illness and has been greatly influenced by psychology. In Hong Kong, nurses and chaplains are the two kinds of personnel who provide spiritual care in the hospitals. Their understanding of spirituality and of care for a person are likely to have been implicitly or explicitly influenced by the psychological literature. I find that the term spirituality in the healthcare literature is diffuse, drawing on various different notions, which results in a confused understanding. It is difficult to come to a consensus about definition. The term is so vague that some people would rather talk in terms of total patient care, rather than separate out spirituality. I would argue, however, that spirituality is very important on its own. The vagueness of the term is its strength and value, as well as its difficulty.

Chapter 3 : Religion and Spirituality in the Healthcare Service

This chapter looks at spirituality in relation to religion. Christianity is the specific focus because of its importance in Clinical Pastoral Training and in the Hong Kong healthcare service generally. I would argue that confusion in the understanding of spirituality in the healthcare service is due, firstly, to a contested relationship between religion and spirituality in that context. Secondly, there is a confused understanding the anthropological terms used within Christianity. Thirdly, there is a separation of spiritual care from its religious root, that is, pastoral care.

Chapter 4 : Clinical Pastoral Training: From the West to Hong Kong

In the rapid development of Hong Kong Clinical Pastoral Training (CPT), confusion has arisen and a resulting lack of direction. The debate about the form and structure of CPT was bequeathed from the past to the present and from the United States to Hong Kong. This chapter looks at the importance of continuing the legacy of CPT through an understanding of the "Living Human Document". I argue there are differences in understanding between the two "fathers" of CPT that led to a split early in the movement. The conflict was then manifested in the creation of the new College of Pastoral Supervision and Psychotherapy (CPSP) after its split from the Association for Clinical Pastoral Education (ACPE) in 1990. This difference between CPSP and ACPE was also manifested during the development of Clinical Pastoral Training in Hong Kong. However, the differences facilitated the development of the movement in both the U.S. and in H.K. I do not consider it necessary to affirm a single "best" model for CPT, yet the spirituality of caregiving cannot be separated from its origin.

Chapter 5 : The Influence of Chinese Culture

From daily encounters with different personnel in the hospital, I determine that there is a confused understanding of spirituality in the Hong Kong Chinese healthcare context. This is because of linguistic complexity surrounding the term spirituality in the Chinese language. There is also a difference between traditional Chinese medicine and western medicine, which still affects concepts of health among Hong Kong Chinese. Fundamentally, it is a difference between an eastern anthropological holism and a western dualistic holism.

Section II: Empirical Research

Chapter 6 : Research Design and Methodology

In this chapter, I first link back to the theoretical perspectives that influenced the design of my research. I then identify the knowledge gap that the research aims to fill. I clearly explain the way I have planned and conducted the study. I argue that the research design enables me to connect my purpose for the study to the collection process and finally leads to enhancement of my supervisory practice in clinical pastoral training.

Chapter 7 : Narratives of Three Hong Kong Chaplains

This chapter analyses the data and discusses the three chaplains as a group. Each chaplain's narrative is first outlined under six headings, namely, background information, understanding of spirituality, spiritual care practice model, difficulties in practice, the Clinical Pastoral Training experience, and ways of resolving the conflict. The chapter ends with a general discussion of the understanding of spirituality of Hong Kong chaplains and the dynamics of the different influences on this group within CPT.

Chapter 8 : Narratives of Three Hong Kong Nurses

This chapter analyses the data and discusses the three nurses as a group. Each nurse's narrative is outlined under the same headings as those of the chaplains (above). This chapter also ends with a general discussion of the understanding of spirituality held by Hong Kong nurses and the dynamics of the different influences on this group within CPT.

Section III: Discussion, Recommendations and Conclusion

Chapter 9 : Discussion of Data: Answers to Research Questions

This chapter is an overarching discussion of the two groups of spiritual caregivers. The chapter provides an answer to questions about the understanding of spirituality of Hong Kong Chinese caregivers within CPT, and the kinds of influences that might have shaped their understanding and practice. Based on insight from the empirical research, I set out recommendations to enhance my professional practice as a CPT supervisor. These recommendations also become the answer to the third research question, about how CPT might address the needs of spiritual caregivers. The whole chapter relates my fieldwork back to the literature.

Chapter 10 : Conclusion

Chapter 2

Spirituality in the Healthcare Context

Introduction

I have chosen to start my exploration of spirituality in the healthcare context, because this context is central to my research questions. Spirituality is a highly debated and even mystical concept, yet it is commonly used in daily life and in the healthcare environment. The word has attracted many definitions and a lot of discussion within the nursing healthcare literature. It is amazing that the usages and definitions can be so varied and wide-ranging. In the following paragraphs, I argue that despite the fact that the concept of spirituality is diffused by varied definitions, the term is very important in its own right. Instead of engaging in circular arguments about the reality of spirituality to show its validity, I affirm that it is crucial to understand the connotations of related concepts, the tasks they perform and the context in which they are expressed in the world of healthcare. This enables healthcare professionals to be flexible, while at the same time being specific, in order to address the diverse needs of people in crisis.

Having been a registered nurse, a chaplain and a supervisor of Clinical Pastoral Training, I consider that the existence of complex and varied definitions shows that spirituality is a very important concept in healthcare. People want to find a unitary and clear essence for spirituality, spiritual care and spiritual needs. This was also my intention when I first approached the topic. It seemed natural and right that with a universal or definitive ontology of "the spirit", healthcare professionals would have a common language in which to communicate, and thereby avoid confusion and misunderstanding. Having reviewed the nursing healthcare literature, I agree that the definitions are various. The term is vague and its meaning keeps changing. Spirituality has been used so loosely that it is non-referential and non-specific. Some people then talk instead in terms of total patient care and argue that there is no such thing as spirituality. I affirm that spirituality as a universal human phenomenon does exist, but agree there is no unitary essence to spirituality. Instead of attempting to find an authentic single definition, I would say that in all those varied definitions, there are enough similarities to form three family

resemblances. The sum of these parts is not greater or equivalent to the reality. However, the groupings show that first, the concept of spirituality has limits; second, there is no need for a clear and unitary definition to prove validity, since the varied definitions themselves reveal the importance of spirituality; and third, the various concepts of spirituality indicate both the complexity of human beings and the specificity of healthcare.

2.1 Spirituality as a Unifying Force

At the heart of many discussions about the reality of spirituality, there are three main arguments. First, spirituality is defined as a unifying force. Several authors (Stallwood and Stoll, 1975; Stoll, 1989; Tanyi, 2002; Mcsherry, 2004) investigate the concept of spirituality by exploring possible meanings associated with the word spirit, which has its origin in the Latin *spiritus,* meaning breath, wind and air. The word spirit relates to the unique spirit of an individual that is the life force, the essence and energy of the being. Many writers develop their definition of spirituality to clarify or expand upon this concept.

Stallwood and Stoll (1975) use different circles to illustrate the four dimensions of human nature, the physio-psycho-social-spiritual, and the relation between these dimensions. The outermost circle represents the physical body. The physical body enables a person to relate to the world via the five senses. The second circle depicts the psychosocial dimension. This is associated with self-consciousness, personality, intellect, morality and will. The psychological aspects are further influenced and shaped by social environment and culture. Within the spiritual realm is the potential for awareness of God. However, this has to be defined by the individual. Nurse theorist Stoll (1989) uses a further two-dimensional approach to show the relationship between the horizontal and vertical dimensions of spirituality. The vertical line is used to represent the mystical-transcendental domain. The horizontal line describes the relationship that exists between self and others. For Stoll, spirituality is developed throughout life. During times of illness, the spiritual need for love, trust and forgiveness becomes the focus.

The above nursing models emphasize the dynamic, integrated and complex nature of the human being with its different dimensions. Spirituality is an integral aspect of an individual's health. It is an integrative dimension, which interconnects and pervades all levels of an individual's experience. Though these models seem quite old and Stoll's schema can be described as dualistic and functionalist, many studies in nursing echo the view that spirituality is the unifying force and integrative energy that is manifested in the self, and reflected in a person's being, knowing and doing (Burkhardt, 1993; Goddard, 1995; Mcsherry, 2004). However, Dawson (1997) has observed that when metaphorical language is used for spirituality, the metaphorical easily becomes the real thing. A definition of spirituality as being like a unifying force and integrative energy becomes spirituality *is* the force and energy. The two can easily replace each other.

The understanding of spirituality in relation to religion has been extensively discussed in the health literature. Tanyi (2002, p. 503) argues that spirituality is an "inherent component of humans….spirituality now is a much broader concept than religion". In this family of definitions, spirituality is a dimension present in all individuals and a concept that embraces all human experiences. It is therefore universal, pervades all cultures and is not limited to people with religious sensibility. For this reason, spirituality is different from religion. Spirituality represents the essence and core of a being. Stanworth (2004) argues that spirituality is the aspect of the being that connects to the infinite. Hall (2006) refers the connection to the sacred; Ray and McGee (2006) to the higher powers; and Miner-Williams (2006) to the numinous. McSherry (2006, p. 85) claims that spirituality is "a transcendental force which unites us with the whole of creation". For Chung et al. (2007), spirituality is about transcendence. Swinton and Mowat (2007) argue that it is in terms of this mode of spirituality that the National Health Service and World Health Organization (1998) claim to serve people of all faiths and none.

Also as part of this group of definitions, spirituality is seen as one of the four dimensions of the human, and is also the essence of the human being that integrates and unifies the whole. It is multidimensional and involves transpersonal connectedness with the supernatural/nonmaterial dimension. It moves beyond the biopsychosocial in terms of expanded consciousness. Therefore, it is a metaphysical and transcendent phenomenon,

which includes beliefs related to transcendence, the incorporeal, immaterial and mystical. Spirituality in this group is more ethereal and abstract than in others, yet it is universal, and is core and fundamental in every human being.

2.2 Spirituality as Related Themes of Spiritual Needs

Secondly, spirituality is defined as related spiritual needs expressed by patients. While there may be ongoing discussions about the reality of spirituality among healthcare professionals, the needs of patients in pain and suffering is of central importance. Patients have indicated wanting help with overcoming fears, finding hope, finding meaning in life, finding spiritual resources; or finding someone to talk to about peace of mind, dying and death (Moadel, et al., 1999). Discussions about spirituality in this group reflect the needs of the people who are suffering.

In this group of definitions, common themes and attributes of spirituality emerge. Spirituality is described as a quest for meaning and purpose, the search for meaningful relationships, love, hope, commitment, a sense of the holy, and connection among people (Burkhardt and Nagai-Jacobson, 2000; Narayanasamy et al., 2002). According to Fitchett (2002), spirituality relates to at least seven dimensions: purpose and meaning; a sense of obligation to live out professed beliefs; experience and emotions; courage and willingness; formal and informal communities to share beliefs; a source of authority; and where we turn for guidance.

The importance of spirituality has thus been well affirmed in the healthcare context. Spirituality not only enhances general well-being and improves health outcomes (Ellison and Levin, 1998; Thoresen, 1999; Koenig and Cohen, 2002), but also enables people to transcend in times of crisis and leads to a sense of unity with the ultimate (Friedemann et al., 2002). Puchalski (2006) affirms that spirituality has become the subject of discussion in much healthcare literature. The importance of spirituality is especially significant in palliative nursing, when physical healing seems hopeless. Spiritual issues always come to the forefront of patient concerns in times of chaos and distress (Williams and Faulconer, 1994; Breitbart and Heller, 2003). Even when spiritual needs are ill-defined by cancer

patients in late stages, a therapeutic focus on spirituality, meaning, and identity issues can prevent depression, loss of self-value and reduce suicidal desires (Gibson et al., 2004). For neuro-oncology patients (Nixon, et al., 2010, pp.2259-2370), spiritual needs include "supportive family relationships, emotional support, help with loneliness, religious needs, a need to talk, a need for reassurance, ease for anxiety, solitude and denial, plans for the future, thoughts about the meaning of life, end of life decisions, and discussions about beliefs". According to Hsiao, et al.(2011, pp.950-959), at least four spiritual needs emerge from Taiwanese cancer patients: "the need to foster hope for survival and obtain a peaceful mindset; the need to fulfill the meaning of life and preserve one's dignity; the need to experience more reciprocal human love; and finally, the need to receive assistance in facing death peacefully". As Heather et al. (2015) would like to conclude, it is important to attend to patients' spiritual needs as part of comprehensive cancer care. A positive correlation occurs between spirituality and well-being.

In this category of definitions, spirituality is not mystical or metaphorical. It reveals its importance from the perspective of patients' needs, which have and can be practically addressed by healthcare professionals. Spirituality is universal, yet is subjective and unique to each individual, revealing the complexity in healthcare and the specificity of individual needs. Burkhardt and Nagai-Jacobson (2000) argue that today, anything that has special significance for the individual can be counted as an expression of spirituality. In this way, spirituality is extended to everybody in a profuse and loose definition. Anything that is of special interest to somebody can be added to the list.

2.3 Spirituality as a Vague and Unclear Concept

Thirdly, spirituality is often seen as non-referential and vague. The term spirituality is principally drawn from ancient wisdom, various religious traditions, belief systems, cultures (religions) and popular psychology, and has entered the healthcare world over the last forty years and ramified itself in different ways. The concept here is so diffused and liberally defined it can cover anything from quiet contemplation of nature to mountain biking at dusk (Miller and Thoresen, 1999). The term keeps changing and is used in endlessly different ways within this group of definitions in the health literature.

Sometimes it does not refer to constant essences within people or in the world. This lack of clarity can nullify, or at least significantly reduce, the practical utility of spiritual care nursing (Bash, 2005a, 2005b; Clarke, 2006). Carrette and King (2005) challenge the added value provided by spirituality. When relevant experience and emotional investment is elucidated in psychological or aesthetic terms, what makes it specifically spiritual? When anything that can be called a spiritual need must be addressed, why call it spiritual care instead of just patient-centered care? John Paley (2008, pp. 3-18) further argues that so-called "spiritual needs" are mostly emotional and practical family problems of an intensified kind. Although he agrees that there is depression and despair in the palliative care setting, the spiritual pain or distress associated with the search for meaning and purpose, the terror of death itself, and "why me?" suffering questions can be clearly understood as "existential distress". From a reductionist and naturalistic perspective, he argues that "experiences are best understood in health psychology, social psychology, pharma-psychology and neuropsychological terms, requiring no reference to the transcendent, the infinite or any other non-naturalistic concept". The idea of spirituality only confuses patients and clinicians and conceals "effective approaches to supporting patients in distress". As the ontology of spirituality is non-referential and vague, it really has no legitimate use or value. The National Secular Society (2009) agrees that within evidence-based and resource-limited healthcare services, spirituality has no important place and should be excluded as a category for understanding and provision.

Swinton and Pattison (2010, pp. 226-237) would agree that the term spirituality cannot refer to constant essences in the world, but that does not mean it is not important. The "vague" and "thin" description of the language is not its deficiency, but its strength. First, not all languages and concepts are referential. The value of spirituality is in its "performative" and "expressive" nature, denoting "sites of resistance, void and absence in health care". The voices of people with significant intellectual or physical disabilities are always excluded. They cannot express their concerns and experiences, such as hope, love, and purpose. For them, spirituality cannot be expressed as essence, yet it is functional and helpful (Post, 2000; Kalra, 2007). Spirituality refers in a practical way to their "discomfort and resistance in the face of the exclusion and narrowing of quest that they engage in" when they are living their lives (Swinton and Pattison, 2010, p. 233).

Love, connectedness, purpose, and meaning of life have been downplayed within current treatment approaches, and have to be reclaimed (Murray and Zentner, 1989; McSherry and Draper, 1998; Tanyi, 2002). Spirituality functions as a sensitizing concept that draws our attention.

Secondly, the importance of a language does not lie in its clearness or its specificity. Spirituality is vague and not specific, yet "can counterbalance the distorting tendencies of specificity" (Neville, 1995, p. 61). The task is to listen and understand the "function" and "direction" of the language that points to an "absence" in healthcare. There may be specific incidences in healthcare where patients are unable to express their "spiritual needs". In these circumstances, spirituality can "assert the significance of [the] foundational similarity" of a complex human being (Swinton and Pattison, 2010, pp. 226-236). Spirituality is important in pointing out the "absences" in the current bio-medical focused caring, which was once expressed in religious language. It is functional and practical to point out uncomfortable lacks in patient care and practical hoped-for presences that healthcare professional can address. It is therefore the context within which these interpretative actions take place that is significant.

Thirdly, spirituality is an important concept in its own right, even though the meaning is varied and keeps changing. According to Carrette and King (2005, p. 3), "it would be a mistake to appeal to some authentic meaning for the term spirituality, as if such concepts were not embedded in a rich and contested history of usage that shifts according to changing conditions and social agendas". Sheldrake (2007), who has looked into the brief history of the development of spirituality, finds that it has long been a word emerging from different contexts and interpreted in various ways. Even within the apparently stable formal religions, there is a diversity of understanding with regard to what spirituality is, and the meaning is still developing according to the context, culture and historical period. Spirituality itself is a social construction with interpretations that are ever-changing, emergent and dialectical. The significance and value of spirituality is in its ability to evolve and develop and sometimes be understood in very different or contradictory ways. This just indicates the flexible nature of language, the complex nature of human beings and particular needs in healthcare.

From the above discussion, it emerges that for this group of understanding, the meaning of spirituality is diffused, vague and emerging, which can be confusing, but the concept is still considered important. The strength of language lies in its vagueness, flexibility and evolutionary nature. To look for an authentic meaning for spirituality just leads to a circular argument. Instead, the meeting of spiritual needs requires an interdisciplinary approach based on various perspectives, and calls for a complex and prompt response in healthcare, so as to enable people to attain their fulfillment and answer their life questions in times of crisis.

Conclusion

There are many different understandings of spirituality from the theoretical healthcare perspective. I agree that the definitions are varied and it is difficult to arrive at a consensus. However, I have argued that there are some common ideas that run through the confusion that can be used as points of orientation. Even though the term is vague and diffused, such that some people would rather talk about good patient-centered care, spirituality is important, useful and functional in healthcare. There is not, and there is no need for, any kind of unitary and universal definition or essence of spirituality. The vagueness and lack of clarity surrounding the term is its strength and value. Instead of focusing on finding a universal definition for spirituality in the healthcare context, it is more beneficial to understand the connotations of its related concepts, the tasks they perform, the languages in which they are situated, and the people and contexts in which they are used. This approach enables healthcare professionals to be flexible, while being specific at the same time, in addressing the diverse needs of people in crisis.

Chapter 3

Religion and Spirituality in the Healthcare Service

Introduction

This chapter is about the way spirituality is understood in relation to religion. In chapter two, I demonstrated that spirituality is a term with a lot of different meanings. I sought to group some related concepts of spirituality into three families: spirituality as a unifying and transcendence force; as needs expressed by patients; and simply as a vague and unclear concept. At the end of the chapter, I concluded that even though the understanding of spirituality is diffuse, it is an important and useful concept that points to absences in healthcare. The varied connotations of spirituality reveal the complexity of human beings and the specificity of healthcare. In this chapter, I move on to discuss spirituality in relation to religion in the healthcare context. The confusion about spirituality arises not only because the term is diffuse and vague, but more importantly, because of the confused relationship between religion and spirituality. With special reference to Christianity, I argue that different understandings of the various anthropological terms in the Bible cause confusion about spirituality. There has also been a separation of spiritual care from its Christian root (i.e., pastoral care). Because of this separation of spirituality from relationship with God, the concept has become fragmented and confusing.

3.1 Spirituality, Religion and Human Health

I visited a patient as a chaplain once, and introduced myself as a spiritual care worker in the hospital. He did not quite understand what that was, but as I was in hospital uniform, he accepted the visit. He only knew that I was a caregiver and he did have some worries to share at that time. The moment he found out that I was a pastor, he asked me if he was going to die soon. He thought that I would not have visited him at that time otherwise. He thought that the medical report he was waiting for must be bad and the doctor would not be able to heal him. Some religious person had thus come to help him seek godly healing.

This example was not unique in my experience as a chaplain. I realized that there is confusion about spirituality and spiritual care. This is due to a confused understanding of spirituality in relation to religion.

Smith (1963, p. 20) in his *New Approach to the Religious Traditions of Mankind*, refers to religion "as something that one does, or that one feels deeply about, or that impinges one's will…offering reward or binding one into one's community." Psychologist Allport (1967), in his classic work about personal religious orientation and prejudice, divides religion into its extrinsic and intrinsic aspects. Religion is extrinsic when people utilize it to serve some other ultimate interest, while for intrinsically religious people, the master motive is religion itself. They try to internalize it and live out the religion. Ellis (1980) defines religion as beliefs, faith and practices that point to a superior being, force or power. Dombeck and Karl (1987) add that religion is an organized system of faith, a particular set of rites and worship. For Wulff (1997), the word religion, which originates from the Latin word *religio*, designates a greater-than-human power that requires a person to respond so as to avoid bad consequences.

The role of religion in human health has changed over the years. In the past, when little was known about the human body, religion was closely associated with healing. At times when medicine was not well developed and when the restoration of physical health was difficult, religious persons would help the sick by appealing to supernatural forces. They did not need to be priests or physicians, because the healing came from God. Physical care was closely intertwined with religious practices. The care of a person could not be separated from religion or religious spiritual care. The understanding of spirituality was placed within this religious framework. Religion and spirituality were so closely connected that the two terms were frequently used interchangeably in the healthcare literature (Kreidler, 1978). However, in the Enlightenment, a deep wedge was driven between religion and reason. For complicated reasons, which I will not go into in detail here, the relation between religion and knowledge disintegrated and became fragmented (Toulmin, 1990). What emerged thereafter was a bio-medical model of human health. Healthcare was now seen as a kind of empirical science based on factual knowledge. Religion on the other hand, is about values, ethics or other ethereal matters. It has nothing

to do with the world of facts (Johnson, 2010). Therefore, anything about the person to do with God is religion, which is opposite to knowledge based in health science. This changed understanding of a person in the healthcare context was influenced by the study of psychology.

Psychology is the study of the human soul. MacDonald and Marcia (2006, p. 4) note that leading figures in the field of psychology, including Sigmund Freud, Albert Ellis and Carl Rogers, devalued religion. They were known to view "religion as cognitive falsehoods, irrationalities to be challenged and jettisoned for healthier psychological perspectives". In their understanding of a person, religious experience was not rational. It was personal and could not be generalized. Religion was therefore not the concern and interest of the study of psychology as a social science. However, more recently, and with a revived interest in spirituality, there has been a paradigm shift in empirical research in the field of healthcare psychology. People accept that in the inquiry about a person, both "nomothetic" and "ideographic" knowledge are important and needed (Swinton, 2012, pp.100-104). Nomothetic knowledge helps us understand people in illness in general. There are therefore typical symptoms when patients are in grief over their loss of health. At the same time, ideographic knowledge helps us to understand the uniqueness of a person. For example, meaning-making in suffering is personal and particular. Both types of knowledge are required for the understanding of a person as a whole. Recently, many studies have enhanced our knowledge of a person in illness and in health. There are important insights into the relationship between religion, and the physical and psychological health of a person (Koenig, 2001; Paloutzian, 2005; Pargament, 2007; Hood et al., 2009). Today, religion intertwines with healthcare in surprisingly diverse ways.

In the development of healthcare services, spirituality and religion continue to be debated concepts. The relationship between them is also unclear. Religion and/or spirituality have been affirmed and incorporated as important dimensions in the healthcare context. There are claims made for a positive connection between religion and well-being, including greater happiness and life satisfaction; lower levels of stress, smoking, depression and anxiety; improvements in coping and more positive attitudes towards marriage and

attachment (Oppy, 2012). There is also other evidence showing that spirituality is positively related to quality of life, self-esteem and reduced anxiety etc. (Swinton, 2012). However, there are at least three kinds of challenges to this type of research. Firstly, some of the studies are carried out using poor methods. Secondly, the relationship between spirituality and religion has not been clearly identified in the research. People emphasize the importance of spirituality and say that they are not dealing with religion. Yet, there is no commonly-shared definition of spirituality (Visser et al., cited in Swinton, 2012). Thirdly, most healthcare literature tends to assume religion is monolithic. Religion is treated as if it means the same thing to all people. Indeed, religion is not something general. It is not merely a set of beliefs, but is something that has to be shared by the one who holds those beliefs. These beliefs can affect one's perspective on nature and the people around. These beliefs can also be reflected in shared rituals. In illness, these beliefs can continue to form and shape the person's experiences, attitudes and understanding of life (Swinton, 2012). Indeed, there are studies showing that the term "religious" is meaningless. It is the particulars of specific religions that have health-bringing capacities. For example, Abu-Raiya and Pargament (2012) discuss four more developed aspects of religion which indicate there is a connection with well-being, namely religious involvement, religious motivation, religious prejudice, and religious coping.

Although there are arguments about the validity of such research, religion and/or spirituality have been reincorporated into the discourse on healthcare services. The interest in the study of religion, spirituality and health does not stop here. These studies are important, not in the sense that religion and/or spirituality are affirmed in healthcare, but because they show that the relationship between spirituality and religion remains confused, despite years of healthcare development. I argue that the confusion surrounding spirituality, religion and human health is due to the confused understanding of the relationship between them.

3.2 Spirituality in Relation to Religion in the Healthcare Service

There is confusion about spirituality in the healthcare service. This is because of the diffused understanding of the term spirituality on its own, as well as the myth surrounding the relationship between religion and spirituality in healthcare. The two concepts even conflict with each other.

In today's healthcare context, with a sort of "spirituality revolution", the term "spirituality is being favored above religion" (Tacey, 2012, p. 474). There are similarities and differences between the two concepts. However, the understandings of the two are sometimes conflict with each other. There has been a decline in institutional and authoritative religion, yet there is growing recourse to spirituality in life. People emphasize the importance of spirituality and borrow from religion different kinds of spiritual practices to enhance health. Moreover, people will say that they are spiritual, but not religious. They are interested in having mystical and transcendent experiences, yet they do not want to identify with specific religious traditions. They are open to and accept multi-religious ideas. In the healthcare service, there is therefore a demand for an awareness of and respect for individual and cultural diversity. I would argue that the confused and conflicting relationship between spirituality and religion is partly because of the separation of spirituality from its religious root.

Regarding the understanding of spirituality in relation to religion, there are two dominant approaches that have taken root within the healthcare profession (Tacey, 2012). Firstly, spirituality is seen to be able to exist without religious traditions. Spirituality and religion are two distinct constructs. Their differences are emphasized under this approach. Secondly, and contrastingly, spirituality and religion are seen to be similar in many aspects. Spirituality cannot flourish without religion. There is a close association of religion with spirituality.

Advocates of spirituality as an independent construct claim that spirituality is a dimension present in all individuals. It represents the essence and core of a person's being. It is therefore universal and not limited to people with religious beliefs. Gorsuch (1993) argues that when spirituality is within a religion, it refers to the capacity to enter into the core of a particular tradition. On the other hand, spirituality outside of religion

refers to the capacity for a deeper dimension of experience. It is more about personal beliefs, values and behavior. Paulson (2005) claims that the root of spirituality is to embrace all human experiences. Religious experience is only one part of it. Spiritual experience can be prior to religion and need not go back to the origins of the tradition. In this way, spirituality is generally regarded as a broader term, which has both religious and non-religious forms. Swinton (2012) adds that both the religious and non-religious forms of spirituality help to name and point to a series of concerns and lacks in healthcare that are very important. Cook (2013) argues that equating spirituality with religion is likely to lead to a misunderstanding of their respective roles in health building. They are distinct constructs that inform peoples' lives.

Those who advocate spirituality is closely related to religion claim that there are at least three reasons for the association. Firstly, both spirituality and religion have positive correlations with health on similar issues. These include quality of life, reduced anxiety, hope and social support etc. Ellison and Levin (1998) explain that religion is an important shaper of a person's belief. The set of beliefs and the system of symbols from religion not only shape a person's understanding in illness, but also promote positive self-perceptions, regulation of individual lifestyles, provision of coping resources and the generation of positive emotions.

Secondly, spirituality and religion affect meaning-making in suffering. Spirituality is not only a dimension that contributes to health, but it also expresses a person's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, humanism etc. (Association of American Medical Colleges report, 1999). Therefore, in times of crisis, spirituality integrates the personal and interpersonal dimensions and transcends cultural, religious, psychological, social and emotional aspects. Sheldrake (2010) emphasizes that searching for the ultimate meaning and purpose of life in sickness may be about confronting the problem of good and evil, and liminal human experiences such as birth and death. Therefore, spirituality and religion are closely related in meaning-making, which is very important in illness.

Thirdly, religion has long been a part of human culture and tradition. Liturgy and worship in the church, together with other formative practices for those who are secular, reflect

people's ideas and beliefs. To separate spirituality from religion is to separate it from its past, history and memory. A Dutch psychologist, Geert Hofstede (2001; 2005), who writes extensively on culture, states that we as individuals connect to universals through the medium of culture. Culture is likened to onions with different layers. At the center are the core values of the individual culture. Rituals and ceremonial conventions are in the second layer. The third layer consists of heroes, real or imagined, while the fourth layer is made up of artifacts. This multilayered approach to culture can be used to explore both the language of the church and the language of the culture. Vanhoozer (2007) defines culture as "works and worlds of meaning" (p. 21). It is the "sum total of people's voluntary works", expressing in objective form "their vision of freedom and being fully human" (Rhea, 2011, p. 8). In this sense, religion is so integrated into a person's beliefs and existential life, that caring for a person is to understand that person-in-culture/religion. Thus, when we ask what religion and spirituality mean and how they are experienced by human beings in a physical body, maybe we should ask what humans, as spiritual beings, experience. We are not human beings having spiritual and religious experiences, but instead spiritual beings having human experiences as a whole. Spirituality is inextricably tied to religion. They are closely related and dependent on each other.

In the healthcare context, the understanding of spirituality is unclear, partly because of its confused relationship with religion. The two concepts also conflict with one other. After extended research into spirituality in relation to religion, Schneiders (1986, p. 273), concludes that, "the two began in a peaceful unity" but "the two partners in the relationship matured, each at a different rate of speed and in different ways." Tacey (2010) claims that spirituality has become an "autonomous field in its own right" (p. 474). There is a separation of spirituality from its root. Regardless of whether spirituality and religion can exist independently, or whether they are closely related in religious and non-religious forms, or how much they are alike or different, spirituality and religion are nevertheless regarded as two distinct concepts in the healthcare context. The confusion in the relationship is partly because there is a separation of spirituality from its origin in religion.

3.3 Christianity and Spirituality in the Healthcare Context

I have shown how spirituality has become separated from religion. In this section, with a special focus on Christianity, I would like to show firstly, that there are conflicting views in Christianity itself about spirituality, arising from the various anthropological terms in the Bible, which leads to the monism-dualism debate about the central doctrine of the *Imago Dei*. I will then argue that the separation of spirituality from its religious origin is actually a separation in the relationship between God and human beings in Christianity. The confusion over spirituality in the healthcare service is because of this separation in relationship. There is thus separation of spiritual care from its original root, pastoral care.

I choose Christianity as the reference for religion in the discussion not because Christianity is more important than other religions, but because of its importance in Clinical Pastoral Training (CPT) and in the Hong Kong healthcare service. Firstly, theological study (Bachelor of Theology, BTh, or Master of Divinity, MDiv) and one unit of CPT are the pre-requisites for employment of chaplains in most Hong Kong chaplaincy offices (Association of Hong Kong Hospital Christian Chaplaincy Ministry, 2015). Secondly, Clinical Pastoral Training is based in Christianity and is open only to Christians and Catholics. (In Hong Kong, many people see Christianity and Catholicism as two different religions.) Thirdly, while medical educators consider how and what aspects of spiritual care should be taught in the medical curriculum, it is not uncommon for Hong Kong Christian nurses and doctors to take clinical pastoral training on their own, in order to enhance their understanding of self and God and to serve God more effectively in their profession.

3.31 Conflicting understanding of spirituality in the Bible

First of all, there are conflicting views of spirituality in the Bible. The understanding of Christian spirituality comes from the word “spirit” in the Bible. In the Old Testament, words for “Spirit” or “spirit” are the Hebrew *nephesh* and *ruach*. *Nephesh* has frequently been translated as “soul”. It has a variety of meanings and is depicted as an individual life force in Leviticus 17:11. It can also be read and referred to anatomically as the throat, neck or stomach. In Psalm 105:18, it is the bodily desire or appetite for food and drink, breath and sex. It is the seat of emotions and moral dispositions. It can even mean a dead

person (Numbers 5:2; 6:11). *Ruach* is a term which refers to wind or moving air. It has been translated as "air", "anger", "cool", "courage" and "quarters" once; "vain" twice; "blast" four times; "mind" and "side" six times; "breath" twenty-seven times; and; "wind" ninety-four times. It is understood as a vital force, power or energy which animates living creatures, although *ruach* refers more frequently to the spirit of God than to the human spirit (Wolff, 1974, p. 42). In Genesis 2:7, God "breathed into his nostrils the breath of life; and the man became a living being". This verse is often used as the foundation for an understanding of humans, who are unique of their kind.

In the understanding of a person, Genesis describes humans as unique because of the image and likeness of God, the *Imago Dei*. However, because of different perspectives on the word spirit, there are different understandings of what constitutes a person. Some would take this verse to support the body-soul dualism of a person. God is depicted as "implanting an immaterial substantial soul into a material body. Earthly life begins with the incarnation of a spiritual substance in a physical substance" (Cooper, 2000, p.33). In his *Anthropology of the Old Testament,* Wolff argues, however, that *ruach* is not an immaterial substantial soul, but a vital force; the creaturely power which comes from the Creator. *Nephesh* can also more sensibly be read as "person" or "self", which represents the whole person rather than some immaterial aspect. The different understandings of spirit in the Old Testament thus lead to different understandings of the person.

In the New Testament, the word for "Spirit" or "spirit", which appears 288 times, is *pneuma.* Luke uses the word *pneuma* to signify deceased, non-fleshly, yet bodily-formed human beings (Cooper, 2000). For example, in Luke 24:37, when Jesus appears to his disciples on Easter Sunday evening, they think that they are seeing a *pneuma*. It has also been translated as "life", "wind" and "spiritually" once; "ghost" 89 times; and "spirit" 123 times (King James Version). There is another word, *psyche*, which is the Greek word for soul. In Matthew 10:28, "Do not be afraid of those who kill the body (*soma*) but cannot kill the soul" (*psyche*). In the Pauline writings, there are other anthropological words used, including *sarx* and *kardia*.

There is a resulting argument about the nature of a person because of the complex and pluriform nature of these anthropological terms in the New Testament. The discussion of

"mind", "flesh" and "spirit" in Romans is traditionally used to support the body-soul dualism of a person. Hebrews 4:12 is even used to support a trichotomy of personhood (Hoekema,1986). However, Sheldrake (2010) would argue that Paul might not have intended to pick out distinct parts or faculties. It is not the contrast of body and soul, or of the physical and the spiritual, but the contrast between two kinds of attitudes in life that he is aiming at. In Romans 7:23, Paul speaks metaphorically about the law of sin, the law of mind and the law of the Spirit of life (Averback, 2017). He is talking about how the Holy Spirit works to transform the entire perspective of our inner world, something that the law cannot change, and which empowers us to live as children of God.

The word "spirit" in the Bible carries many different understandings. The problem is compounded by the inter-relationship of the terms stemming from the Hebraic tradition on the one hand and the Hellenistic tradition on the other (Jewett, 1971). Whether the Bible refers to a person with a soul-body distinction, or this is only a symbol for life remains contested. There are thus conflicting views about spirituality in Christianity and this in part leads to confusion in the understanding of spirituality.

3.4 Separation of Relationship Between Human Beings and God

The confusion about spirituality in the healthcare context is not only because there are conflicting views on spirituality in Christianity itself. The confusion is also because there is a separation between human beings and God.

3.41 Christian spirituality as dual knowledge

Averback (2000, pp. 111-126) claims that spirituality in Christianity is a dual knowledge. It is about the understanding of the human being and of God, which mutually inform, expand and correct one another. This is like a "two-way double" road, although not two separate roads that do not meet. Knowledge of God and people can meet together at either end, or at any location along the way. Each side of the knowledge has to be duly recognized by the other and it is not about valuing one over the other. This is affirmed by John Calvin at the start of his *Institutes of the Christian Religion* (cited by Averback, 2006, pp. 35-39): "Nearly all the wisdom we possess, that is to say, true and sound

wisdom, consists of two parts: the knowledge of God and of ourselves. But, while joined by many bonds, which one precedes and brings forth the other is not easy to discern". Therefore, in Christian spirituality, the understanding of a person is inextricably tied to the knowledge of God. Moreover, through the lens of Henri Nouwen's thinking, I consider that the understanding of each also depends on the understanding of the relationship between them. Spirituality in Christianity is a kind of relationship between God and human beings. The separation of this relationship can cause confusion about spirituality in the healthcare context.

Understanding of Christian spirituality has been in different manifested ways in different periods and traditions. According to the Sheldrake's classic work, *A Brief History of Spirituality* (2013, p.16), spirituality is "the way our fundamental values, life-styles, and spiritual practices reflect particular understandings of God, human identity, and the material world as the context for human transformation". However, the word has also gone through many changes from the ages of the early church, through monasticism, the Reformation, and the age of Reason before reaching postmodernity. Throughout history, a wide range of spiritual traditions have arisen within Christianity. There was Origen, Evagrius and Augustine in the early church; Puritan spirituality, Early Quakers, and Ignatius Loyola in the age of the Reformation; Pietism, Wesleyan and Orthodox spirituality in the eighteenth century; and Evelyn Underhill, Dietrich Bonhoeffer and Thomas Merton's spirituality in the twentieth century. Entering into the twenty-first century, Sheldrake concludes that Christian spirituality has never been a "static or a single, simple reality" (p. 222). Christian spirituality, which was "Jewish in origin", has now developed with a distinctive flavor and content. Different traditions have persistently adjusted and presented themselves with particular emphases, ways of life and practices throughout time. In order not to over-generalize, I will refer to the spirituality of Henri Nouwen in order to anchor the discussion.

3.42 Spirituality of the wounded healer

Nouwen was a Dutch-born Catholic priest. He was a professor, psychologist, pastor and patient. I choose him for my discussion, not because he is more important than the others, but because he is relevant to this context for three reasons. Firstly, his personal life

experience makes Nouwen a well-known wounded healer. After nearly two decades of teaching in universities, he went on to work with mentally and physically handicapped people. He became the resident pastor at the *L'Arche* Daybreak community in Richmond Hill, Ontario. Though he was a pastor of others, he suffered depression himself. As a patient, a pastor and a psychologist, Nouwen straddled the boundaries of healthcare, Christianity and spirituality. He was a practical theologian, reflecting upon and integrating his frustrations and experiences. When he travelled to give speeches in different places, he always insisted on taking along one of the mentally impaired people from his community. He made them part of his life, work and journal writing. Secondly, in Hong Kong, Clinical Pastoral Training (CPT) is mainly for Christians. As a Catholic priest, Nouwen has been accepted by Hong Kong church communities of different traditions, including both Protestants and Catholics. He published 39 books and authored hundreds of articles and reflections in his interest areas of psychology, pastoral care, spirituality, social justice and the community. Most of his writings have been translated into Chinese. These works include *Intimacy, Letters to Marc about Jesus, Heart to Heart* etc. His writings and reflections, rooted in his own personal experiences, are relevant to the CPT motto: action/reflection/action. Thirdly, Nouwen was involved in CPT training in the U.S., the model Hong Kong has adopted. His work was greatly influenced by Anton Boisen, the father of CPT. All of these factors make his views on spirituality and spiritual care relevant to our discussion of Christian spirituality.

3.43 Relational spirituality of the wounded healer

The main focus of Nouwen's work is spirituality. His view on spirituality has to do with authentic being. This authentic "I am" (in the world) is in fact a how "I-am-with-Others". In many of his books he describes authentic being as a life of wholeness before the face of God. Therefore, authentic existence is about a kind of relationship with God, with the self (intrapersonal) and with other people (interpersonal). Nouwen further points out that the relationship with God is the foundation for the other two relationships, i.e., the self and others. It is only because of this relationship with God that the human can have "a new way of being in the world without being of it". It is this capability of being that

allows human beings to transcend, “going beyond” the here and now; “connecting or belonging and giving life” and “being home” (Nouwen, 1988, p. 133).

The claim about this authentic identity of the human being is important. Human beings discover the true identity of who “I am” by relating to God’s spirit. However, humans cannot initiate a relationship with God. It is more about being aware of His unconditional love and being ready to respond. This human being can then respond by having a relationship with God and discovering his/her true identity. We are the beloved children of God. We are created and accepted as we are. Therefore, the true identity of self is not based on what we accomplish or on what others think of us. When comparing ourselves with others, we always feel that we are not good enough and not worthy of acceptance. This self-rejection brings a false sense of the self and forces us to remain guarded in relationships with others. Only when we understand and experience that this being is sacred and that we are embraced by a loving God, do we begin to know our true identity. “To acknowledge the truth of ourselves is to claim the sacredness of our being, without fully understanding it. Our deepest being escapes our own mental or emotional grasp. But when we trust that our souls are embraced by a loving God, we can befriend ourselves and reach out to others in loving relationships” (Deirdre, 2000, p. 99).

Nouwen places a lot of emphasis on spiritual discipline for the growth of a person and for an awareness of authentic identity. He refers to the heart as the center of being, where the human-divine encounter occurs. A broken and sick being can be healed and transformed to become an authentic self in the heart by the Holy Spirit. Nouwen’s sixty-three God-centered spiritual imperatives helped him to work through his depression and find self-acceptance. The means of transformation is “to make available the inner space where God can touch you with an all-transforming love” (Nouwen, 1988, p. 75). Spirituality is about the way in which people experience God’s presence. It is the Holy Spirit that pervades and unifies the whole person.

Nouwen’s spirituality is, above all, relational. The meaning of life comes also from one’s existence in this relationship with God, with one’s own self and with fellow human beings (Nolte and Dreyer, 2010).Yet, the three relationships are rarely neatly separated in the experiences of daily life. Certain themes occurring in different relationships are in

"various tonalities and often flow into one another as the different movements of a symphony" (Nouwen, 1975, p. 20). Under this broad framework of relational spirituality, human emotions, daily life experiences of isolation, fear or hatred, and personal religious experiences, are all embraced in the whole person and unified by God's Spirit.

According to Nouwen, Christian spirituality is a kind of relationship rooted in God, with oneself and with others. The separation of spirituality from religion—Christianity in this context—is a separation from God's spirit. It is a separation from a special relationship with God. Spirituality then becomes fragmented and disintegrated. How might this confusion be manifest in the healthcare service?

3.5 Spirituality of Christian Caregiving

Christian spirituality is relational spirituality. It is the foundation of Christian caregiving. The separation of spiritual care from Christianity causes confusion in the identity of the caregiver.

Christianity talks a lot about care. Christian caregiving is often identified with the work of an ordained person or persons with designated religious leadership roles. The care is referred to as pastoral care. The object of care is the people of God. The foundation is primarily rooted in the teachings and life of Jesus. Rizzuto (1998) considers Jesus' healing and care as mainly spiritual healing to bring peace and to reconcile the relationship of the human person with God. Meaza (2013) argues that Jesus is the healer of the body and spirit alike. Mogabgab (2011, p.16) claims that the word "care" finds its origin in the word *kara,* which means to lament, to mourn and to "share in pain". To care is firstly, to "cry out" with the ill, and to "recognize their pains" in our own hearts. To care is then to "enter into the world of the broken" and establish a "fellowship with the lonely". To care is also to "be present" to sufferers even when nothing can be done to change their situation. In a broader meaning, pastoral care is helping or shepherding, especially for suffering, troubled, or perplexed persons (Plantz and Lantos, 2014). In the following paragraphs, and through the lens of the relational spirituality of Henri Nouwen,

I argue that spiritual care in Christianity cannot be separated from the identity of the caregiver, who is a living reminder of Jesus.

3.51 Pastoral caregiver as the healing reminder of Jesus

For Henri Nouwen, the importance of caregiving is not located in the how and what of the care. It is the identity of the caregiver that matters most, and the caregiver's spirituality, which has to do with living centered in God. As the living reminder of Jesus, a caregiver has three roles. S/he is the healing, sustaining and guiding reminder of Jesus. In the caregiving, it is Jesus who is healing both the caregiver and the cared-for. Therefore, the spirituality of Nouwen's caregiving cannot be separated from the caregiver's identity as a living reminder of Jesus.

The first role of a caregiver is to be a healing reminder of Jesus. As a psychologist, Nouwen attests to the importance of psychology in helping people gain insight into someone's pain, anger, grief or loneliness, and their being in the world. Psychology explains why and how painful memories damage the self-esteem of a person. However, his understanding of a person goes beyond psychology in a kind of relational spirituality. For Nouwen, the pain of a person is the sinful and broken condition of all humans in the world. Therefore, the pain of an individual is connected to all of humanity. Because of the suffering of Jesus, the world has been redeemed and there is ongoing redemptive work within the individual and in the world by God's spirit. Pain is thus not only connected to the pain of humanity and the world, but pain is a reminder of the need for God's healing. It is also a reminder of God's work in the world. The pain of an individual, the suffering world, and God's salvation and healing are all connected.

A caregiver is a healing reminder of Jesus. With the help of contemporary behavioral science and an understanding of psychic forces, the caregiver is able to gain insight into the human experience of pain. However, s/he is not a doctor attempting to take away the pain as a physician of the soul. Instead, as a reminder of Jesus, s/he has to reach out to the painful and sinful condition. The purpose is to make a connection between the story of individual human suffering and the suffering of Jesus. When people's broken relationships with self, the world and God are restored again, healing can happen. A new unity that is entire and integrated can be reclaimed as part of a redemptive event. In this

way, Christian spiritual care is not about psychological skills and techniques to accomplish healing. It is about a way of living in the Spirit. The caregiver has to discover God's work within his or her life and make the connection between this little life and the great life of God. This way of living is a "new way of being in the world" in which the relationship with God, intrapersonal relationships and interpersonal relationships can be restored (Dreyer, 2003, pp. 715-733).

Nouwen emphasizes the importance of the spirituality of the caregiver in being a healing reminder of Jesus. S/he has to first live, heal and love in the Spirit, because the caregiver is a wounded healer. S/he is one who always has to first consider an intimate relationship with Christ. This is "a spirituality, a spiritual connectedness, a way of living united with God" (Nouwen, 1987, p. 34). During his depressive experiences when working as a pastor in the Last Daybreak Community, Nouwen encountered God and his own pain through sixty-three spiritual imperatives. These were later published as *The Inner Voice of Love*. The spirituality of the caregiver is therefore about a way of living in the Spirit, which encompasses work and rest; eating and drinking; prayer and play. It is about a kind of prayerful life whose understanding cannot be independent of that of the Origin. Through a personal relationship with God, and the establishment of a pastoral relationship with the cared-for, the possibility of the caregiver being a healing reminder of Jesus can be realized.

3.52 The pastoral caregiver as the sustaining reminder of Jesus

The second role of the caregiver is to share in the hardship and sustain the pain of others. This is achieved through a kind of creative presence and absence. Nouwen acknowledges that presence with others is not the obvious human response to suffering. What we desire most with suffering is to flee from it or find a quick cure. Spiritual caregiving as a practice of compassionate care therefore requires a "total conversion of heart and mind" (Nouwen, 1983, p. 8). It requires an "inner disposition to go with others to the place where they are weak, vulnerable, lonely, and broken" (Nouwen, 1979, p. 91). It requires the caregiver to discover his/her center of life and to experience God's presence in solitude. Only when God's compassion is credible in one's own world, can one be truly present with others. Through this kind of true presence, caregivers can sustain others by

providing comfort and encouragement in difficult circumstances. In the caregiving process, they have to listen and respond to the voice of Love. Only then can they direct the sick and the suffering to the source of passion and forgiveness, which is healing and liberation.

As a sustaining reminder of Jesus, the caregiver is "the embodiment of God's compassion in this world" (Nouwen, 1983, pp. 15-16). Apart from presence, absence in ministry is also important. The caregivers serve as "the God who is with us is the God who forsakes us". They live "before God and with God, [they] live without God" (Bonhoeffer, 1972, p. 360 as cited in Nouwen, 1987). The caregiver serves as Jesus, who says, "It is for your own good that I am going, because unless I go, the Advocate will not come to you.…But when the Spirit of truth comes he will lead you to the complete truth" (John 16:7, 13). In this way, absence from ministry becomes a kind of sustaining absence as it creates space for God's spirit to work with the sufferer. The caregiving can be sustained with a kind of creative interplay of presence and absence.

Nouwen emphasizes the importance of solitude in caregiving. The caregiver has to be reflective, be aware of his/her own struggle and be able to articulate the inner world of the self. Solitude in caregiving is then to challenge the caregiver to develop intimacy with God and unmask the illusions of busyness and usefulness. Solitude is not a place where there is peace and retreat, but a struggle with demons and an encounter with God (Nouwen, 1981, p. 51). In solitude, the caregiver is able to regain a true pastoral identity with God. "It is in intimacy that we develop a greater intimacy with people and it is in the silence and solitude of prayer that we indeed can touch the heart of the human suffering to which we want to minister". In solitude we can "stop judging". Judgment creates "the distance, the distinction, which prevents us from really being with the other". Only in solitude can we "stop evaluating and thus become free to be compassionate" (Nouwen, 1981, p. 21).

3.53 The pastoral caregiver as the guiding reminder of Jesus

The third role of a spiritual caregiver is to provide spiritual guidance. There are times in life when people face ethical or religious difficulties. A guiding reminder of Jesus is to confront by challenging these people to confess and repent, and to inspire so that people

can recapture their vision with courage. More important, however, is to let the Spirit of God, the divine counselor, shine through us and bring light to others. This is to create space so that the person can come to his/her own unique understanding of God and life. In this way, guidance does not merely depend on professional skills or psychological competency. It is not only about analysis and mirroring. It is through authenticity and the willingness to listen and accept, that the person can develop his/her own independence and personal relationship with God. It is through prayer that all human pains and sorrows, conflicts and agonies are relieved.

To be a guiding reminder of Jesus is to understand God's work with the living human and "to distinguish with a growing sensitivity the light and the darkness in the human heart" (Nouwen, 1971, p. 63). Meditation on God's word is therefore indispensable to a caregiver if they are to radiate hope, joy and life in despair, sadness and death. It is God's words that pervade first the whole earthly being of the caregiver, who can then help other people to distinguish the Holy Spirit from unholy spirits. It is God's words that form and transform the spirituality of the caregiver, who can then guide people to a vital transformation of soul and body and of all their relationships.

I have looked through the lens of Henri Nouwen in order to demonstrate that spirituality in Christianity is relational spirituality. It is the foundation of Christian caregiving. It shapes and forms the identity of the caregiver, who is a living reminder of Jesus. S/he is a healing reminder of the past, a sustaining reminder in the present moment; and a guiding reminder for the future. S/he is in a special relationship, rooted in God, connecting with a self who is healed by the Spirit and establishing a kind of pastoral relationship with others.

3.6 From Pastoral Care to Spiritual Care

Thus far, I have explored an understanding of spirituality in relation to religion under the framework of Christianity. I consider that the confusion about spirituality is because firstly, there are conflicting understandings of spirituality within Christianity. Secondly, there is a separation of spirituality from relationship with God. Below, I discuss how spiritual care has been separated from the root of pastoral care, thus causing confusion in

the healthcare service. I use the United States as a reference, because the model of HK Clinical Pastoral Training is mainly adopted from the U.S.

In the caregiving context of the United States, pastoral care was replaced with spiritual care as part of a monumental growth in interest in spirituality. The term spiritual care began to enter the vocabulary of health care chaplaincy in the 1980s as a more inclusive and less specifically Christian or pastoral care term. This was a response to increasing religious pluralism. In the mission statement of the Association for Clinical Pastoral Education (ACPE), the term pastoral care was replaced with spiritual care. There was also exclusive use of the term "spiritual care" in the White Paper on Professional Chaplaincy published in the Spring 2001 issue of *The Journal of Pastoral Care*. The editor of the journal affirmed that this fundamental shift from pastoral to spiritual is logical and helpful on at least three levels. Firstly, it reminds the caregiver of religious diversity, both among patients and in the chaplaincy profession. Secondly, it safeguards and honors the unique spiritual values of each individual in the healthcare milieu. Thirdly, it underscores the importance of holism. In recognizing that there is a human longing for wholeness and health, spiritual care is a way of mobilizing the spirit in response to human needs. Spiritual care is no longer the privilege of religious persons. The care of ministers has extended outside the walls of the church.

In the past, caregiving was limited to theologically-educated ministers or chaplains. Today, healthcare professionals and psychologists without any theological or religious training can engage in spiritual care. Spiritual care is a form of psychologically-oriented therapy. Pattison (2010, pp.351-366) finds some elements of spiritual care that are regularly mentioned include: "training in attentiveness; addressing the challenge of empathy; sensitivity to the configuration of physical patient space; cultivation of a sensitivity to what it means to truly give space to the individual patient; and how to express fundamental respect and love towards those who are cared for as persons". Spiritual care is now the activity of attending to, understanding and nurturing groups and individuals in finding meaning and connectedness with significant relations, including material, immaterial, psychological, social, living, dead and transcendent objects.

On the transition from pastoral care to spiritual care, Tacey (2012) notes that contemporary spiritual care is more about the exploration of the self than of the spirit. Spiritual care has become an alternative metaphor for the personality, *psyche,* person or self that is the core of an individual. In the past, pastoral care was an emphasis on the person (pastoral) whose identity is from God, who cares in Jesus and with His Spirit. Today, spiritual care is about the (spiritual) dimension of the person being addressed. A lot of emphasis is put on addressing the spiritual needs of individual patients. In the past, caregiving was related to God. It was about relationships. It was a caring pastoral relationship that mimicked the presence of God, through which other relationships could be restored. It was about connecting the self with God through surrendering of the self. Today, spiritual care refers to the art of transcending the ego by exploring deeper regions of the personality. In the past, pastoral care was a kind of shepherding that involved putting everyday life under the light of faith or the ultimate reality. Therefore, all living problems were spiritual, as they involved relationship to God (Faber and Schoot, 1965). Today, spiritual care demands evidence-based processes and sounds more psychologically sophisticated, in terms of both the language and skills involved.

As we can see from the above, pastoral care and spiritual care have different emphases. Fundamentally, there has been a separation of spiritual care from its pastoral care root. It is a separation of spirituality from Christianity and the separation from a relationship with God. There is thus a loss in the identity of the caregiver.

Conclusion

In this chapter, I have shown that confusion about spirituality stems from the confused and conflicting relationship between spirituality and religion. Through the discussion of spirituality in Christianity, I have argued that the differing perspectives on spirituality within Christianity lead to even more confusion. There is a separation of spiritual care from its pastoral care root. This equates to separation from a special relationship with God. The understanding of spirituality has disintegrated and become fragmented. There is a corresponding loss in the identity of the spiritual caregiver.

Chapter 4

Clinical Pastoral Training: From the West to Hong Kong

Introduction

Thus far I have discussed a confused understanding of spirituality in the healthcare context. In this chapter, I discuss the spirituality of caregiving within Clinical Pastoral Training (CPT). This is to go back to the origin of the training in the U.S. and its transfer to Hong Kong, and to allow history to provide insight into the direction of Hong Kong CPT in its development.

The introduction of the clinical pastoral movement broke down the barrier between medicine and religion in the healthcare service. With the support of Richard Cabot, Anton Boisen started Clinical Pastoral Education (CPE) in the U.S. in 1925. It was later referred to as Clinical Pastoral Training (CPT). It is my opinion that Clinical Pastoral Training is beneficial for spiritual caregivers, both chaplains and nurses. It offers a platform for dialogue between religion and medicine, between the self and others in different kinds of relationships, and between the past and the future. I agree that there are different dialogues and different views about the structure, the goals and approach of CPT and that these differences can create conflict. Conflict began early in the movement among the founders of CPE. There were at least two divisions among the early progenitors. However, the conflict also led to the flourishing of the training and informed both spirituality and its practice. In the following discussion, I focus on the conflict between Anton Boisen and Richard Cabot, and consider whether this conflict was carried onwards when CPT was first introduced in Hong Kong.

4.1 Starting with Delusions

Anton Boisen (1876-1965) is one of the progenitors of the twentieth-century clinical pastoral movement. The movement he founded was aimed at breaking down the walls between medicine and religion. He was also the first to suggest that pastors should

include “the study of living human documents” in their training (Gerkin, 1984). The vision of the whole movement strangely originated in Boisen’s experiences and delusions during a fifteen-month psychiatric incarceration in 1920. History confirms that he was right when he wrote of himself later that he was never more correct than at the time he was admitted into the hospital. The calling and commission from that time became his whole life’s work.

Boisen was well known for intense internal conflicts that drove him into insanity and hospital several times in his life. During the first episode, his close fellow pastor brought a copy of Freud’s *Introductory Lectures* to the hospital. This work changed Boisen’s life. He found an authoritative voice of understanding. As Freud had said, a disordered mind like his could be the result of the struggle for integration when facing internal powerful conflicts. Boisen knew that his own struggle was rooted in his sexual desire, which collided with his wish to be faithful to his religion and family. During his first hospitalization, Boisen also found that no physician would listen to him. Their instructions could not cure him or help him in his struggle. As he put it, the psychotic episodes made him a better and more integrated person when he struggled to understand them. “[My] cure has lain in the carrying through the delusion itself” (as cited by Lawrence, 2016).

When Boisen was released from hospital after his fifteen-month incarceration, he immediately went to Harvard to learn from well-known physician and ethicist, Richard Cabot. Inspired by Freud, Boisen wanted to find a better means of offering pastoral counselling for psychiatric patients like himself. He sought help and learned Cabot’s case method approach. Boisen had the vision to train ministers clinically so that they could be competent enough to treat emotionally disturbed persons. Cabot also wanted to see ministers trained clinically as adjuncts in the healing of patients. Their visions coincided. After two years, with both the theoretical and financial support of Cabot, Boisen became chaplain of Worcester State Psychiatric Hospital in 1925. He also started a clinical training program for clergy in 1930. The purpose was to train ministers to work with psychiatric patients, using the resources of psychology and religion. The program taught ministers to listen and make connections. It trained them to give patients time to tell their

stories, which Boisen labelled “the listening cure” from his reading of Freud (Lawrence, 2017, chapter 28).

Their common enthusiasm for breaking the barriers between medicine and religion led to co-operation between the two founders and the start of the movement. In the mid-1930s, a three-month experience of Clinical Pastoral Training became a prerequisite for almost all Protestant seminarians. However, Cabot had a strong bias towards anything related to psychology or psychiatry, while Boisen encouraged the marriage of psychology and religion. The relationship between them was thus doomed from the start. In the following discussion, and through the lens of “the living human document,” we can see that while there were a lot of similarities between them, their differences finally led to a split.

4.2 Understanding the Living Human Document

Asquith (1976, 1992, 1995, 2000) has been researching and writing about Boisen for about forty years. He says that there are three enduring aspects to Boisen’s concept of the living human document. Firstly, there is the sacredness of individual texts and narratives. Secondly, the study of human experiences is vital for completing the understanding of God, and therefore the method of studying, i.e., studying human experiences, is also the content of understanding. Thirdly, theological reflection helps us rebuild the connections between life and language, theology and psychology.

According to Boisen, every human being is unique, important and sacred as a living text. In his book *The Living Human Document*, Gerkin (1984), applies the methods of biblical hermeneutics to pastoral care and counseling, including an assumption about the sacredness of human experiences .The deepest experiences of a person, whether in their spiritual struggles, psychological perspectives on grief, interpersonal conflicts, family relationships or illness, all demand the same respect. No matter how strange the language used might be, it is worthy of being respected, heard and has an authenticity of its own. For Boisen, there is no sacred versus secular. There is no individual or social, only “actual social conditions in all their complexity” (Boisen, 1951, p. 185). His book *Religion in Crisis and Custom* records his call to and passion for the study of different

social groups' experiences. Pastors, religious leaders and organizations are known as interpretive guides and agents of hope in an individual and societal hermeneutical crisis (Asquith, 2015).

Another of Boisen's books, *Exploration of the Inner World*, discloses his disappointment at the shallow medical treatment he received during his hospitalization. He was also angry at the indifference of the religious community towards psychiatric patients. But most significantly, he proclaimed the importance of a psychoanalytical approach to mentally disturbed patients (Lawrence, 2016). Boisen considered that pastoral identity lies in the calling to be physicians of the soul. Through building a pastoral and therapeutic relationship with patients, pastors can make use of Freud's talking cure in order to heal, i.e., listening to and connecting all the riddles in the suffering of the patient. The purpose of the ministry is "saving souls…that of sin and salvation" (Boisen, 1951, p. 3). Boisen also emphasized that this living human document not only points to those being cared for, but also to the caregiver. If pastoral authority is embodied by firsthand discovery in the realm of spiritual life, Boisen stimulated ministers to claim this new authority for themselves, to explore their own inner worlds and theologies, and to be sensitive to those struggling in life and death (Thornton, 1970). Boisen's psychological stance towards the person is therefore from Freud. It also cannot be understood without his theology. So what was his theological stance?

Boisen's view of humanity originated in his theology. As mentioned before, he argued that a person's understanding of God cannot be completed without an understanding of human experiences. He recognized the sacredness of human beings, yet he was convinced about the total depravity and inherent sinfulness of humanity. Human nature is easily inclined to inherited tendencies that prevent the realization of higher personal and social potential (Boisen,1945). Asquith interviewed Hiltner, who knew Boisen very well, as they worked together during the clinical pastoral movement. Hiltner notes that it is hard to place a theological "label" on Boisen as he had an "unusual diversity of theological views and interests" (Asquith,1982). He comments that an old-fashioned liberalism, plus a morality that extended back to his Indiana religious culture, appeared simultaneously in Boisen's theological thought.

Theology provided Boisen with a framework to care for each person. Yet Asquith (2015) notes that Boisen rejected "mainline" churches. He felt that supreme loyalty or blind loyalty within churches caused faith to be devoid of clear objectives. He was critical about traditions that did not have the ability to absorb new insights and the depths of human experiences. He disagreed with religion that resulted in a church that was a mere body of doctrine or ceremonies. The church should be "a dynamic fellowship whose central task is the perpetuation and recreation of religious faith" (Boisen, 1945, p. 210). For Boisen, the pastor or the caregiver might not possess the truth. It is by caring for and witnessing the cared-for battling and triumphing in life struggles, that the caregiver can be informed of the practice of soul care. Both the cared-for and the caregiver gain a better understanding of God through the relationship. Therefore, Boisen's theology is empirical, with an emphasis on reflection.

Boisen emphasized theological reflection. His work was autobiographical. He had his own reflections on a variety of issues in his life. On the issue of breaking the barrier between religion and medicine, he asked: "What is the place of our Christian religion in the new world? What has science taught us about God and man, Christ and the Bible, sin and salvation?" (Brown, 1914, p. 10). When discussing the problem of evil, he reflected that it was hard for him to reconcile the existence of evil with the idea of a good God. Yet he referred to God as "the internalized fellowship of the best"; God "need not be infinite but He is ultimate for us, the great dominant personal force with whom we have to do and to whom we owe our allegiance, and that for me would be enough" (Boisen, 1910, p. 251).

Boisen's psychological stance came from Freud and was rooted in his liberal theological stance, which appears to be evangelical in its emphasis on sin and salvation. Salvation is an individual experience between a person and God. It does not necessarily take place within the church context. Salvation is "the release from the sense of isolation and the restoration to fellowship with God which follows immediately upon the experience of forgiveness" (Boisen, cited in Asquith, 1982). What was Boisen's approach when putting forward the idea of the living human document?

Boisen's method and vision for case studies were revolutionary and reflective. According to Pruyser (1967, p. 218), Boisen was "an organizer (who) enriched the cadre of psychologists of religion with men of different professional qualifications". His work involved careful scrutiny, seeking patiently and systematically, laying foundations, and building understanding. Thornton (1970) affirms Boisen as a scientist. Using surveys, questionnaires and statistical analyses, Boisen applied rigorous, but imaginative scientific methods to religious phenomena. His contribution to the field of psychology is undisputed. Asquith, receiving the 14th annual Helen Flanders Dunbar award in 2015 CPSP plenary (College of Pastoral Supervision and Psychotherapy), considers that in the midst of psychosis and enormous internal conflict, Boisen was on a quest to "make sense of his own experience and to validate the meaning of his own suffering". He made a "collegial and cooperative inquiry" into the story of each person, believing that it might "reflect back" to the inquirer and help in making more sense out of his/her own story. Hiltner, drawing from his personal experience with Boisen, reports that Boisen functioned more as a self-appointed psychotherapist. He was interested in exploring people's illnesses in the hope of healing patients. He always encouraged pastors to work as scientists and think of alternatives in order to obtain differential diagnoses for patients.

Because of Boisen's efforts, the laboratory for the psychology of religion shifted from the university to the hospital, with patients becoming sacred texts for observation and detailed study. He was a scientist who held strongly to his own theological perspectives and also his psychological experiences/stance, yet he was eager to bring about the unification/integration of religion and medicine through theological reflection and scientific study. Through the living human document, Boisen informs us of his understanding of pastoral identity, pastoral authority and the values and beliefs of spiritual care.

4.3 Richard Cabot and the Art of Ministering

Richard C. Cabot (1869-1939) was a medical doctor. He made history by introducing social workers into the hospital in 1905 and foresaw the important place for pastors in the hospital in taking care of patients' spiritual needs (Thornton, 1970). He encouraged and

supported Boisen to become the first chaplain in the hospital. He had significant influence on Boisen, including fostering his eagerness for accurate diagnoses of patients' problems and the case study method in learning and teaching. Cabot's participation in the early formation of Clinical Pastoral Training led to his recognition as one of the fathers of the movement (Asquith 1982). In the following, I look at his understanding of the living human document and his beliefs about spiritual care.

The Cabots were an old New England family who produced a succession of distinguished citizens. Richard Cabot was professor of clinical medicine at Harvard Medical School. With a passion for the larger problems of humankind, he moved from medicine to Harvard's Chair of Social Ethics and settled as a professor of Sociology and Applied Christianity at Andover Newton Theological School. As a doctor, Cabot was optimistic about human beings. His optimism was due to his confidence in the wisdom of the human body. In his classic writing, *The Art of Ministering to the Sick*, he describes *Vis Medicatrix Dei*, the power of nature, as the goodness of God. With his medical understanding, Cabot attested to God's love in the human body, in which a great healing power always "reserves, makes balance, compensates, defenses and wins the fight of life against death". There were signs from his medical experience that God has "an extraordinary bias" in favor of healing activity in humans, whether they look healthy or are sick inside (p. 130). Cabot was also concerned about the needs of a whole person. He therefore always included different personnel in caring for the sick. The first chapter of *The Art of Ministering to the Sick*, clearly shows his philosophy of caregiving, in its description of the three aims of calling the minister to the sickroom, namely (1) "to counteract the evils of specialism"; (2) "to give a devotion such as only religion can permanently inspire"; and (3) "to care for the growth of souls" (Cabot, 1947, p. 3).

The central goal of a chaplain is always to devote him or herself to "the growth of souls". As a doctor with faith in a "natural force", a pastor has to be aware of and trust this force that is beyond the self, but that works for health and righteousness. Therefore, the pastoral role is to meet people's "growing edge" and "feed them with food", i.e. with love; help them to learn a new fact or a new truth; to appreciate the beauty of life and affirm that they are of use/service to others in their suffering. People will then move beyond

their “regret for failure” or “success [which] melts into self-indulgence” into a new expansion and awareness of growth (Cabot, 1947, pp. 13-14). Growth of souls is indeed the decisive mark of the sacred in a human being. This growth is “not toward a goal but in powers such as sympathy, courage, honesty, perspective, tenacity, knowledge” (p. 18). Spiritual life means the growth of the person along the plan of his/her individual nature. This growth is the “ethical absolute” and therefore “takes place in character, not toward character; in wisdom, not toward it” (p. 376). Through learning, experimenting, admiring and sharing, such growth can be exemplified.

For Cabot (1947), the life of pastors and the identity of caregiving depends upon God, that “life greater” than theirs. It is the divine purpose that “gives them worth” and God is the only one the pastors are responsible to and serve. Pastors pray and listen to patients. They act and serve as if God is the third person who is always present. Through quietness and sharing of their own experiences in God, God becomes more real to the patients. Any enduring relationships can only be solid when centered on the life of God. It is God whom both the pastor and the patient have to face, i.e., “The Two Must Face a Third” (p. 172). This encounter not only avoids the danger of missing any perspectives when the two sides are so close in a relationship, it is also recognition that God can be seen at all times. “When a sick man acts with humility, courage, self-forgetfulness or forgiveness, then and there we see creation move on a step. We are eye-witnesses of the creative process which is an act of God. Dully we suppose that God is everywhere, somehow at work, but now we see it” (p. 265). The great calling of God is therefore ministering to the sick at whatever cost to our pride and comfort. We must be humble. The results may not be what we desire, yet when we have done our best, we may leave the outcome to God. His creative spirit never ceases to work its way within and among us (Johnson, 1966).

Cabot pointed to a similarity between the training and the role of a doctor and that of a pastor. He also emphasized the importance of a collaborative relationship between physicians and the clergy in order to meet the needs of the patient as a whole. His greatest concern was the growth of souls, which is connected to health and manifests the importance of suffering. During the caregiving process, the proof of religion is not in the facile use of religious terms or in the clearness of doctrine/belief. It is in a certain quality

of thought and action of which any one person has some, but no one has enough. For Cabot, the pastoral authority and identity towards the sick depends on the love and goodness of God. The pastor is not the therapist, but a help-meet for the therapist, who is the physician (Lawrence, 2016).

4.4 Conflict Between Anton Boisen and Richard Cabot

Boisen and Cabot are regarded as the pioneers of the clinical pastoral movement. As Stokes (1985) notes, Boisen and Cabot, along with other pioneers in the movement, shared the common characteristics of liberal Protestantism. These include the indivisibility of the sacred and the secular, the need for a pluralistic outlook, a belief in the primacy of the human experience of God, and an implicit faith in the modern modes of inquiry of different disciplines for the improvement of the world and the pursuit of the ultimate truth. Their liberal world/human views allowed theology to become a clinical enterprise as much as an academic one (Hart, 2010). However, the co-operative relationship between the two fathers ended in 1930.

In 1930, Boisen experienced his second major psychotic episode after his mother died. He visited Cabot in a psychotic state, referring to himself in the third person. In Cabot's view, Boisen was a sick man. His psychosis was organic. He should not even be a pastor, let alone a trainer of pastors. As the president of the Council for Clinical Pastoral Training for Theology Student (CCTTS), Cabot declared Boisen unworthy of certification. According to Lawrence (2016), who has conducted profound research into the clinical pastoral movement, the relationship between the two would not have lasted in any case for at least three reasons. Firstly, as a victim of the very inadequate medical and psychiatric care of his day, Boisen was primarily interested in psychiatric hospitals. He wanted to engage with patients in depth and build a therapeutic relationship with them. Cabot, on the other hand, preferred general hospitals, as he saw no benefit in working with psychologically disturbed patients. Secondly, as a result of his own experience, Boisen saw the visions and delusions of psychiatric patients as a doorway into the meaning behind their disturbances. In relation to the patient, a chaplain was there to listen to what the patient had to say. The chaplain as a person was more critical in the

psychotherapeutic task than any skills he might have accumulated. However, as an authentic psychotherapist, pastoral care of the unconscious should be psychoanalytically-informed. For Cabot, the pastoral stance focused on the conscious minds of patients. Chaplaincy was more skill-based, because it was about the things that chaplains could do and say, such as praying, bible reading, exhorting, encouraging and so forth. Thirdly, Cabot saw clinical training as education. That is to say, chaplains were learning how to assist patients on a conscious level, so as to pave the way for the real therapist, the doctor. Cabot saw chaplains as help-meets for the physician. The Cabot club therefore considered that chaplaincy training should focus more on didactic lectures and encouraged reading, while Boisen followers placed more emphasis on reviewing clinical cases among peers. Reflecting on different relationships among the peers, patients and other persons, with the assistance of the clinical supervisor was considered important.

While conflicts between the two fathers started early on, there was nevertheless growth within the movement. The 1950s-60s were the golden days of CPT. When Boisen started the training program at Worcester Hospital in 1925, there were only four students. In 1945, the movement had expanded to fourteen training centers. The Protestant religious community took the training seriously. International trainees came from different parts of the world and returned to their home countries to initiate indigenous training programs. The conflicts also helped to clarify many key issues in training and new possibilities for the case-method developed. Nouwen (1968) concluded that this important era was marked by at least three developments. Firstly, there was growing attention to the pastoral conversation. Different methods for analyzing the verbatim reports were discussed. Secondly, there was a growing interest in the relationship between CPT supervisors and trainees and the kinds of psychotherapeutic theories to be applied. Thirdly, there was the growing influence of clinical training in the theological schools. When Boisen died in 1965, the movement had become known in theological education, with numerous centers, including mental and general hospitals, prisons, industrial schools and other institutions established. Various regional and national organizations in the United States joined the founding fathers and left an important mark on history.

The conflict between the two fathers of CPT prefigured the subsequent break in the clinical pastoral community. Yet the differences in the community brought about the development of the movement. Philosophically, the community split into two associations, with each following a different father. The Council for Clinical Training (CCT) looked to Boisen as their spiritual leader, while the Institute of Pastoral Care (IPC) looked to Cabot. CCT sought to link theology and psychology in the work of pastoral counselling. It also tilted toward personal transformation. Meanwhile, the IPC focused on communication skills for clergy, and kept away from psychology (Lawrence, 2016). The split lasted until 1967, when there was a strong desire to have one community again after such a long division. Therefore, even with some dissent, the CCT and IPC, together with Southern Baptist and Lutheran Clinical Training Organizations, agreed to a merger and formed the Association for Clinical Pastoral Education (ACPE). In general, the merger was thought to be a great achievement.

Conflicts between the founders of Clinical Pastoral Training facilitated the development of the clinical pastoral movement in U.S. The movement then travelled from the U.S. to Hong Kong. The first generation of Hong Kong CPT supervisors finished their training in other countries, mainly the United States. They started CPT in Hong Kong more than thirty years ago. In the following, I discuss the development of CPT in Hong Kong.

4.5 My Entry into Hong Kong's Clinical Pastoral World

I completed my first and second units of Clinical Pastoral Training while I was in seminary. At that time, it was called CPE, i.e., a kind of clinical theological education. I was still working as a part-time nurse, while studying for a BTS (Bachelor of Theological Studies). In the seminary, CPE was an elective subject for BTH (Bachelor of Theology) and MDIV (Master of Divinity) students. As a part-time student, I was not supposed to be accepted into the course. However, I was given a special dispensation on request. I was curious and confused about the relationship between religion and medicine. As CPE claimed to be clinical, I hoped that it might provide some answers. In my first unit of CPE, I found some answers and, most importantly, my calling as a chaplain. I then transferred to the BTH and finished the second unit of CPE at the seminary. After

graduation, I became a chaplain. During my years of chaplaincy service, I finished the other two units of CPE. Through all the units of CPE, I had three different supervisors. Two were from Canada and one was from the U.S. Apart from the differences in their individual supervisory styles, each had his own philosophy about education or training. This led me to reflect on what CPE should be.

Afterwards, I started my CPE supervisor-in-training (SIT) programme. My training supervisor was Rev. Tam, who had completed his training and certification in America. During the training, I had the privilege to learn from training supervisors from other centers in some joint SIT sessions. They were all Hong Kong first generation CPT supervisors who had received their training mainly from the U.S. I found that there was a wide divergence of opinion as to what CPT was supposed to be. Some considered that CPT should involve more skills. Spiritual care is not only about listening, but includes spiritual assessment, which requires interpersonal skills. Therefore, an appropriate therapeutic approach should be incorporated into the caregiving process and the necessary skills should be discussed and taught in CPT. Some emphasized the person and the growth of the caregiver. Others said that CPT is a kind of adult education, with emphasis on caregiving; while still others emphasized the importance of reflection and clinical supervision in the process. Some also recommended that Chinese culture and education theory should be integrated into the supervisory theory. Today I am a certified CPE supervisor working in my mother seminary and CPE has been a credit course at the seminary for more than twenty years. Yet the most frequently-asked question among students is still what CPE actually is. Different students often have different opinions about whether it is “education” or “training”.

4.6 The Conflict Travels to Hong Kong

My training supervisor, Rev. Tam, was a certified supervisor of the College of Pastoral Supervision and Psychotherapy (CPSP) in the U.S. His supervisor, Raymond Lawrence, was the founder of CPSP in 1990. Since then, CPSP, together with the Association of Clinical Pastoral Education (ACPE), have become the two main training and certification associations in the United States. The CPSP organizes accredited training and credentials

for supervisory training, pastoral counselling and psychotherapy and clinical chaplaincy etc. It also encourages the formation of CPSP Chapters in places outside the United States for local development of the training. With the encouragement of Lawrence, my supervisor, together with a few diplomats, formed the Hong Kong Chapter of CPSP in August, 2009. The aim was to provide local training and certification for clinical chaplains, CPE supervisors and psychotherapists, in accordance with the standards of CPSP in the United States. The Hong Kong Hospital Christian Chaplaincy Ministry (HKHCCM) is another organization providing credentials for clinical chaplains and supervisory training in Hong Kong. It follows the tradition of ACPE, because the chair of the steering committee (2007) for the development of Professional Chaplaincy under HKHCCM, Rev. Lo, was a certified CPE supervisor of ACPE. It naturally followed that ACPE would be invited as the consultant in the development. The philosophy of ACPE has been adopted in the local training of chaplains and supervisors under HKHCCM. In this way, the differences between ACPE and CPSP in the clinical pastoral movement have manifested in the development of the training in Hong Kong. What then are the differences between ACPE and CPSP?

Raymond, the name that Lawrence likes to be addressed by, is the founder of the College of Pastoral Supervision and Psychotherapy (CPSP) in the United States. He thinks this programme should be called Clinical Pastoral Training (CPT), instead of Clinical Pastoral Education (CPE). I have personally met Raymond several times in past years. He is enthusiastic about contextualized and local development of CPT. He travels to Hong Kong, the Philippines and other Asian countries from time to time with abundant energy, despite being over seventy. He has generously shared with me his own involvement and research in the clinical pastoral movement from the past to the present, from the ACPE to the creation of CPSP.

Raymond was certified as a full supervisor in the Association of Clinical Pastoral Education (ACPE) as early as 1970. He then became an active member of the community. He held various offices at the regional and national levels. As mentioned before, ACPE was the newly-merged federation of 1967, after the long split between the two fathers of Clinical Pastoral Training, CPT. Raymond considers that the creation of ACPE was

governed by the mistaken presupposition that "there must be one controlling organization and one predominant ideology". Many dissident voices were thus suppressed. Moreover, the merger was a trumping of the Council for Clinical Training, CCT (representing Boisen's values) by the Institute of Pastoral Care, IPC (representing Cabot's values). The philosophy of Boisen was being "sold out". In the new ACPE, educational theory replaced psychological theory as the principal adjunctive theory. "Clinical seminars" morphed into "classes". There was a "dethroning of Boisen's psychoanalytic perspective and the enthronement of educational theory" (Lawrence, 2016, p. 2). The clinical training movement shifted its primary attention from the pastor/caregiver as a person, to the interpersonal skills of the pastor. I consider that the split of ACPE and the creation of CPSP in 1990 was doomed from the start of the merge between CCT and IPC, for it was rooted in the conflict between Boisen and Cabot.

The reasons for the creation of CPSP and its separation from ACPE are complicated and multiple. However, philosophically, the creation of CPSP was to advocate the "recovery of soul", i.e. to recover the values treasured by Boisen at the start. As an active member of ACPE, Raymond found that the ACPE had gradually moved away from its history. Although he and his colleagues voiced their concerns about the grim future for the professional community, their complaints were ignored. In 1988, Raymond began to comment on the leadership of the community through the ACPE underground report, saying that it was "theologically bankrupt and concerned with public relations only". There was "a lack of ethics" in the community and "inconsistencies in its response to alleged sexual misbehavior" (Lawrence, chapter 16). Despite the fact that a lot of support was given by other clinical supervisors, no one in the leadership communicated with him. Raymond continued to write the underground report and within a year, calls for a new organization grew. In 1990, together with fifteen other members, the new federation, College of Pastoral Supervision and Psychotherapy (CPSP) was created. It was designed to advocate for the "recovery of the soul", a metaphor that points toward the values treasured by Boisen, but that have since been lost in the ACPE.

The intention of the CPSP founders was to return to the philosophy of Boisen and away from the philosophy of Cabot. It was therefore a shift in focus away from educational

theory to psychology, specifically to psychoanalytic psychology. The founders also agreed to engage in the search for the meaning of human experience and human relationships, with careful attention to the unconscious, rather than focusing on skill development. It was also about rejecting the assaults on male sexuality that existed in ACPE at that time. “Recovery of soul” meant recovering the spirit of Boisen and this later became the covenant of CPSP. The covenant includes, firstly, that the calling and commitment of the members are first and last theological. Secondly, personal authority and creativity are to be most highly valued. Members are mutually responsible to one another for professional work and direction. Small groups called Chapters are to be organized so that members can midwife one another in their respective spiritual journeys. Thirdly, CPSP intends to travel light, own no property and create no bureaucracy. Members are to invest themselves within a milieu of a supportive and challenging community of fellow pilgrims.

The creation of the CPSP ended the monopoly that the ACPE held in the field of Clinical Pastoral Training. After two decades, there are now more than a hundred Chapters in the U.S. and other regions. There are thousands of certified persons, including clinical supervisors, clinical chaplains, pastoral counselors and pastoral psychotherapists. Raymond agrees that the animosity between the ACPE and CPSP may be diminishing with the emergence of a new generation in both communities. However, it is undisputed that the two major organizations, the ACPE and the CPSP can provide “direction, surveillance and leadership” to the clinical pastoral movement (Lawrence, 2016, chapter 16).

The debates concerning the basic values and principles of CPT have been around since the very founding of the training in 1925. Complete agreement has not and will never be reached, from the past to the present, from the ACPE to the CPSP, and from the introduction of the training in Hong Kong more than forty years ago. There has been much development in Hong Kong since then. Currently, there is one seminary and four centers providing CPE. The training varies from one-year and half-year extensive to three-month intensive courses. There is a residency program for chaplaincy training and a training program for lay persons and healthcare professionals. Besides the four standard

units of training, the first generation of supervisors also started local supervisory training about ten years ago. There are now four locally-trained certified supervisors.

I consider that the differences within Hong Kong CPE or CPT are due to the different philosophies between ACPE with its clinical pastoral education and CPSP and its clinical pastoral training. The difference between these two associations is rooted in the conflict between Boisen and Cabot. However, the differences within Hong Kong's clinical pastoral community have brought about the growth and development of the local CPT. I reflect that the disagreements, whether in the United States or in Hong Kong, are not ultimately destructive, but are creative and facilitate growth and development. There has been growth in CPT in the number of training centers, programs and trainees since the movement from the U.S. to Hong Kong. No truth can be possessed by any particular person or organization. It is more important to remain open to new perspectives and to have dialogue with those who may be different.

Conclusion

This chapter has revealed that the conflicts within CPT started early on in the clinical pastoral movement. The debate about the form and structure of CPT has continued. The conflict was manifested in the creation of the new CPSP after its split from ACPE in 1990. The difference between CPSP and ACPE was also manifested during the CPT development in Hong Kong. The difference between Boisen and Cabot has continued from the past to the present and from the United States to Hong Kong.

Chapter 5

The Influence of Chinese Culture

Introduction

When I was a chaplain, whenever I went to patients and told them I was from the spiritual care service, they would look puzzled and confused. If I told them I was a chaplain or pastor who gave spiritual care, they would associate me with church personnel. Christian patients could easily understand what a pastor might do during the visit. However, if I asked them about the state of their spirituality, they thought that I was asking about their church attendance or frequency of bible study and prayer. Non-Christian patients certainly did not know what I was asking about. They tended to think "spiritual care" was about religion and teaching people about God. They would sometimes say that they did not want to talk and refuse my visit. However, if I asked them about their *jing shen*, i.e., good spirit with energy (□ □), a dialogue would open naturally and lead to a caring process. These examples of confusion in day-to-day communication do not happen in a western context. In light of the worldwide interest in spirituality, in this chapter I ask the question: What has happened in the Hong Kong healthcare service in terms of the holistic/spiritual movement? I agree that the concept of holism and the spiritual movement have brought about improvements to Chinese Hong Kong healthcare. However, I would argue that the concept of spirituality sounds strange to a lot of Chinese. This is because, firstly, the term itself in Chinese characters and expression carries very rich meanings with various overlapping connotations. Secondly, traditional Chinese medicine (TCM), which still affects the concepts of health and life for many Hong Kong Chinese, is conceptually different from western medicine. Thirdly, the anthropological conception of a "being" in Chinese is fundamentally in conflict with the dualistic western concept of a being.

5.1 Healthcare Service in Hong Kong

When I was a nurse in Hong Kong in the 1970s, the healthcare service was based on the disease model. There were not many specialized healthcare professionals. Doctors and nurses at that time were responsible for curing physical diseases. There were limited resources in the healthcare field for addressing the huge demands from the developing society. Besides private and government hospitals, subvented hospitals run by organizations with religious or charity background also played an important part in providing healthcare services. Nethersole A.H.M.L. Hospital (or Alice Memorial Hospital in 1887), which was the first hospital in Hong Kong to train local Chinese in western medicine, was founded by the former London Missionary Society. Its mission was to witness Christ's love by rendering holistic care to the sick. (The term "holistic" here falls under the framework of Christianity.) The first hospital chief wrote in his diary, "Our hospital always talks about the Bible with out-patients and every ward has a morning prayer session. We recite the Bible and give sermons to patients. We often quote Bible sayings to encourage patients, whether they are in-patients or out-patients" (Hong Kong Hospital Christian Ministry, 2016).

In 1990, all hospitals in Hong Kong were grouped under the unified and financial management of the Hong Kong Hospital Authority (HA). In 2001, the position statement of HA's holistic nursing section emphasized the importance of holistic healthcare and defined it as "the care delivered to meet an integral, independent individual's health needs including physical, psychosocial, spiritual, cultural and environmental aspects as a whole". Under the management of H.A., Nethersole A.H.M.L. Hospital continued to advocate holistic care. According to its position statement of 2001, a whole person includes "physical, psychological, social, and spiritual" aspects and the goal is "the practice of compassionate care to all patients, families and staff". We can see that a spiritual dimension is formally recognized in the concept of holism in the Hong Kong public health service, irrespective of religion.

The word "holism" originates from the Greek word "holos", meaning whole. Kopelman and Moskop (1981) have surveyed and critiqued the holistic health movement that occurred in healthcare services around the world. They report that people now go to the

extreme of describing a great variety of innovative health care practices as holistic. Charlatans may even exploit the term “holistic health” to gain acceptance for useless remedies. A general characterization of the movement is based on a shared commitment to assumptions like “a positive view of health as well-being, individual responsibility for health, the importance of health education, control of social and environmental determinants of health, and low technology or natural therapeutic techniques” (Kopelman et al., p. 209). The understanding of holism in Hong Kong healthcare echoes the above assumption and refers to caring for the whole patient—care with four different dimensions, instead of merely being related to clinical symptoms (Livingstone, 1996). Interdependence and good healthcare of all of the parts simultaneously determines the nature of the well-being and health of the entire person (LaPatra, 1978). Moreover, the whole can be more than the mere sum of the interacting parts (O’Toole, 2016).

As part of a butterfly effect of the holistic/spiritual movement, regulatory and accrediting bodies in the United States and Europe became more sensitive to the spiritual needs of patients. They began to incorporate the provision for spiritual care into their accreditation standards. The Joint Commission on Accreditation of Healthcare Organizations (1999) has a policy that states: “For many patients, pastoral care and other spiritual services are an integral part of health care and daily life. The hospital is able to provide for pastoral care and other spiritual services for patients who request them” (pp. R1-15). In May 2009, the Hong Kong Government launched a pilot hospital accreditation scheme covering five public hospitals and three private hospitals (Legislative Council Secretariat, 2010). The government engaged the Australian Council on Healthcare Standards (ACHS) as a partner, and implemented a pilot scheme based on the Evaluation and Quality Improvement Programme (EQuIP) of ACHS. It covered forty-five criteria under thirteen standards for evaluating the service performance of the hospitals participating in the scheme. “Standard number one: Governance for Safety and Quality in Health Service Organizations, Criterion: Clinical Practice (12.1.1)” states clearly that “guidelines are available and accessible by staff to assess physical, spiritual, cultural, psychological and social, and health promotion needs”. Moreover, “Criterion: Patient rights and engagement (11.7.1)” states that “policies and procedures that consider cultural and spiritual needs are implemented to ensure that care, services and food are provided in a manner that is

appropriate to consumers/patients with diverse needs and from diverse backgrounds". Therefore, to respect a patient's dignity, culture, and faith, and to provide for their spiritual needs, are some of the conditions that are required in acquiring the qualification. In order to fulfill the accreditation standards, an increased provision of high quality holistic health care was needed. The chaplaincy service, which is supposed to provide spiritual care, flourished in hospitals, both in terms of the numbers of chaplains and the kinds of services provided.

5.2 Chaplaincy Services in Hong Kong

Chaplaincy services first started in subsidized hospitals with Christian backgrounds. Nethersole A.H.M.L. Hospital's Constitution states, "The Hospital will forever act according to our mission, that is, our chaplains will preach for Christ while our hospital will cure patients" (Hong Kong Hospital Christian Chaplaincy Ministry, 2016). Under the framework of Christianity, chaplaincy services in the hospital were mainly evangelical. In the 1970s, Christian hospitals, local churches and theological seminaries started a discussion about "holistic healing" and studied the possibility of sending Christian chaplains to public hospitals. Eventually, before 1980, they successfully held the Conference of Holistic Healing, which set the foundations for chaplaincy services in the future. In 1984, the first chaplain entered a government hospital, Grantham, which marked a milestone in Hong Kong's chaplaincy history. Chaplains who served as volunteers, visited the patients and held evangelical meetings in the hospitals with the support of mainly local churches. In 2006, echoing the worldwide interest in spirituality in healthcare, the hospitals of the Hong Kong North Territories East Cluster, including Prince of Wales Hospital, which is a university hospital, started to change the title of chaplain to spiritual care worker. Instead of being volunteers, chaplains became honorary staff in the hospital, formally under the spiritual care service of the Allied Health Care department. At that time, I was working as a chaplain at the Prince of Wales Hospital and witnessed the change. Chaplains/spiritual care workers were able to gain access to the hospital intranet, which is connected to all patients' private information. We became recognized as healthcare staff members who had to abide by the professional ethics and

hospital policies for all medical personnel. Today, not only is there a chaplaincy department in almost every hospital, but chaplains are formally recognized as healthcare providers. Besides Christians, Buddhists have also been invited to join the service. Chaplains serve not only the patients, but their relatives, and also health care professionals. The services provided include organizing religious activities and liturgies for patients, accompanying doctors in breaking bad news to patients, involvement in palliative care patient meetings and helping patients understand advance directives etc.

In response to the increased standards in mainstream healthcare services, local professional standards for chaplaincy, which had been discussed in the past, were finally implemented. The Association of Hong Kong Hospital Christian Chaplaincy Ministry carried out a great deal of groundwork and surveys. A Steering Committee for the development of Professional Chaplaincy was formed in April 2007. Two documents, "Professional Chaplaincy: Its Role and Significance in Healthcare Service" and the "Code of Ethics for Professional Chaplains", were drafted, opened for discussion and then passed by the Board of Directors in 2009 (HKHCCM, 2016). By the end of 2010, the application for registration of chaplains commenced. According to the types of theological training and the numbers of Clinical Pastoral Training units taken, chaplains could be identified as certified chaplains, registered I and II chaplains and auxiliary chaplains. Although professional development is still in its early stages, this marks a milestone in Hong Kong hospital-based chaplaincy.

In briefly reviewing the healthcare and chaplaincy service history of Hong Kong, I wish to point out that the introduction of the western concepts of holism and spirituality led to a change in Hong Kong healthcare from a disease model to a bio-psycho-social-spiritual model. This in turn led to a paradigm shift in chaplaincy service. Chaplain status has changed from that of a volunteer evangelical to a professional spiritual care provider. S/he co-operates with different professionals in the hospital to provide holistic care to patients. Yet what does spirituality mean to Hong Kong Chinese?

5.3 Chinese Spirituality

Hong Kong is a place where east meets west. An internationally shared and important concept—spirituality—has gradually taken shape in a different language and under a dominantly Chinese conception of spirituality/soul. Healthcare services have developed with an emphasis on spiritual care and holism. From the daily encounters and experiences with chaplains and patients, it becomes apparent, however, that the term spirituality is vague, confusing and can even be misleading. What are the reasons for the confusion? I would argue that although the term sounds strange to Chinese, this does not mean that the Chinese do not have spiritual needs. There are common spiritual needs in suffering as human beings, yet culture and traditional beliefs do play a role. If culture and beliefs have been integrated into the Chinese daily language and concepts that can affect the understanding of spirituality and even the attitude towards suffering, we should first ask "What cultural forces might shape the understanding of spirituality among Chinese people?"

Unruh, Versnel and Kerr (2002) try to define the concept of spirituality that has been used in health literature from 1990, by sorting definitions of spirituality critically into seven related themes, including: 1) relationship to God, spiritual being, higher power, a reality greater than the self; 2) not of the self; 3) transcendence or connectedness unrelated to a belief in a higher being; 4) existential, not of the material world; 5) meaning and purpose in life; 6) life force of the person, integrating aspect of the person; and 7) summative. Yet compared with the extensiveness of discussion in western literature, very little is known about spirituality in relation to Chinese culture (Mok et al., 2004, 2010; Chan et al., 2006). Chiu (2000, pp.29-53) surveys Taiwanese breast cancer sufferers, and finds spirituality is "a journey and a unidirectional evolving process that people experience at different levels of wholeness and integration". As the Chinese view of spirituality is too large in scope to deal with here, I focus instead on some of the local research that illustrates that Hong Kong Chinese share common spiritual needs with all humans in suffering, but that there are also cultural factors woven into their concepts and beliefs.

In a research study of terminally-ill Hong Kong Chinese (Mok et al., 2010), four themes and seven subthemes of spirituality are identified. Spirituality is: 1) life as an integrated whole; 2) acceptance of death as a life process; 3) finding meaning in life; 4) a sense of peace; 5) receiving and giving love in relationships and connectedness; 6) having faith in God/higher power; and (7) being a good person and having a sense of peace. The participants found spirituality to be an abstract multi-dimensional concept, signifying integration of body and mind. The researchers agree from their findings that spirituality is related to relationships and connectedness with others; to a sense of faith; and to living with meaning and hope (Lin & Bauer-Wu, 2003). Spirituality is also considered a broader term than religion, which is similar to the findings of studies in the West (Astrow et al., 2001). However, Chinese participants found meaning in life and felt peace when their personal responsibilities were fulfilled, including serving others and being responsible parents. This reflects a Chinese Confucian background which is concerned with the quest to be a social being rather than a solitary individual. To be human is to be an ethical and good person, rather than "what God wants of a person" as in most western religions. The effects of the cultural beliefs of Daoism and Buddhism are also reflected in quotes such as, "Let nature takes its course" and *Tien Yi,* "I have to let go". Daoism sees the universe and all living things as a unifying force called the *Dao* or the Way. As humankind is an inseparable part of the universe, it has to seek harmony with the cosmos. Therefore, *Tien Yi* (the will of cosmos/heaven) becomes the explanation for illness. In another study with Hong Kong Chinese cancer survivors (Li, 2011), spirituality manifests again as "let nature take its course". The other three manifestations are: joy and peace; connectedness with a higher power; and having a positive attitude towards life. This is to say, since illness and adversity are inevitable in life, one has to accept the reality, and follow or be in harmony with the order of nature. This echoes the Buddhist doctrine which also emphasizes the importance of contentment. Attachment to things, people and events just leads to suffering. Liberation is letting go of the grasp on the world, refraining from pursuing desire in life, and reaching fullness of being. It is one way to reduce death anxiety. Again this echoes *Chuang-tzu* in Daoism, who wrote that ease comes when we stop grasping and tune into Dao, the effortless way of things (Chiu, 2000).

The above studies show that there are common human questions about meaning and the purpose of life. There is the multi-dimensional need for human beings to feel connected and loved, both in local and western culture. However, findings show that for Hong Kong Chinese, living in a place where east meets west, Chinese culture, tradition and religion do have an influence. Participants' cultural beliefs help them create meaning, including their belief in a power beyond themselves and the grandness of nature (Mok, 2010). Traditional and cultural teachings, as well as spiritual practices, provide, empower and comfort Hong Kong Chinese with inner strength and peace (Li, 2011). These teachings and practices are unconsciously integrated into the language of daily life, affecting the Chinese concept of and attitude to suffering. When chaplains ask Hong Kong Chinese patients about their spirituality, the puzzlement they feel does not mean that they do not think about the meaning of life, or that they have no need to feel connected. Instead, I would argue that the Chinese language is rich and pluralistic. It is a very informative system for a culture (Wallner, 2009). For this reason I now look at the language and its characters to reveal additional insight into this conceptual puzzlement about spirituality.

5.4 The Chinese Language of Spirituality

The word spirit, or *ling* in Chinese, has many meanings. There is no consensus among scholars on a Chinese equivalent for "spiritual" or "spirituality". Most Chinese translations of "spiritual" are misleading and confusing, especially when taken out of the context (Wu, 2013). According to *The Oxford Chinese Dictionary* (□ □ □ □), spirit is *ling*, which also means quick/alert/efficacious/effective /to come true /departed soul/coffin. Dean (2001), a physiotherapist professor in Hong Kong, says that spirituality is the totality of the four dimensions of the physical, mental, social and spiritual, encompassed in the phenomenon of *qi*, and that there is no comparable term that exists in western-based Hong Kong healthcare. Mok (2010), a nursing professor in Hong Kong, seeking to understand the spirituality of Chinese terminally-ill patients, defines spirit (*ling*) as *qi*, "the energy with which heaven, earth, the universe and nature are filled" (p. 361). Sophia, a philosopher and also a Traditional Chinese Medicine practitioner,

suggests *jing shen* (□ □) as a translation for spirit, or *ling,* denoting the essence or the life force of human existence. When used together, these two words mean the extra-physical, metaphysical and psychological dimension of a person (De Groot,1875). Therefore, *jing shen,* which is the definition of *ling*, is always used to describe a person who is energetic, focused and vibrant. Other Chinese anthropological concepts related to the spirit or *ling*, include: *jing* (□), *shen* (□), *xin* (□), *qi* (□), *zhi* (□), *hun* (□), *pao* (□) *xing* (□), *yi* (□), and *ziran* (□ □) (Kwan, 2016).

Chinese characters are hieroglyphics, meaning that the characters can tell us a lot about the worldview and culture from which they originate. It is useful to study the most primitive written characters in order to understand the earliest concepts of Chinese concerning the soul/spirit (Smith,1958, p.167). From the Oracle Bone and short inscriptions found on ritual bronzes from as early as the fourteenth to the twelfth centuries BC, the primitive written character *shih* (□) is a meaningful character designating "spiritual beings, the manes of the departed, sacrifices and prayers". Later on, composite characters were formed. According to *Kuo Mo Jo* and other modern Chinese scholars, the character representing the ancestors' spirits is *tsu* (□), the protective god of the soil is *she* (□), and the divine beings are *shen* (□). In the oracle inscriptions, these characters are found to be used together with another primitive character, *kuei* (□), which is a spirit with a somewhat fearsome aspect. A large number of Chinese customs relating to the disposal of the dead continually depict the *shen* as well as the *kuei* as residing in or near the grave. This means that from an earlier time, humankind was thought of as possessing only one soul, and would live on after death on earth for a period as a *kuei* (□). The term *kuei shen* is not divided, but signifies a whole host of spiritual beings (De Groot, 1875). In later centuries, *kuei shen* were used as appositions in the *Classic of History* (*Shu Ching*) and developed along with the *Yin-Yang* philosophy which is the main philosophy of traditional Chinese medicine (Smith,1958).

From this elemental character *kuei*, other composite characters were formed to designate the vital breath, *qi* (□); the soul, *hun* (□), *pao* (□); and the spirit, *ling* (□). An early piece of literature, *Zhuozhuan*, Duke of Zhao, 7th year (771 to 476/403 BCE), provides insight into early Chinese anthropological concepts. It says, "When life begins, there is *pao*. Now that *pao* is there, the spirit is called *hun*. With *pao* and *hun*, one can exploit the material world to enrich one's life. In this way, the *hun* and *pao* become strong" (Ai, 2006, pp. 152-55). In this way *ling hun pao* is a triad in one Chinese soul. The understanding and use of the word spirit (*ling*) is thus complicated and pluralistic. It relates to a lot of other characters and the relationships between words are confusing and have evolved over the centuries. The term *ling* has been adopted and integrated into the main religions of the Chinese, which have further affected the beliefs about and concepts of health.

When used together with different words, *ling* can have more than twenty-two meanings. Compound words involving *ling* that are relevant to the healthcare context under discussion, and which have the meaning of vibrant life force, spirit, or enlightenment are: *xinling* □ □ and *lingxing* □ □ . These two terms are sometimes interchangeable, but each has its own context. *Lingxing* is used more often in a Chinese Christian or religious context. According to *The Oxford Chinese Dictionary* (□ □ □ □), there are two meanings for *xing*: firstly, sex and secondly, of/about. *Lingxing* literally refers to associations of or about the spiritual nature (*ling*). In the Christian context, which is also a western religion, *lingxing* means spiritual life. It is the life which has a relationship with the Holy Spirit, *shenling* □ □ . For Hong Kong Chinese Christians, spiritual life is reflected in church attendance, prayer life and faith. For other religious Chinese, *lingxing* can also be used to describe objects, plants or animals that carry magical powers. In some Chinese folklore, a rock can be worshipped because of its *lingxing,* which gives the worshipper a sense of profoundness and power. Animals that exhibit extraordinary wisdom and have a close understanding of human emotions and heart can be described as *lingxing* (Wu, 2013). *Lingxing* therefore refers to a special kind of wisdom and power that is otherworldly.

According to *The Oxford Chinese Dictionary* (□ □ □ □), *xin* is the heart/mind/intention/center/core. *xinling,* when used together, means deep inside the heart (□ □), the mental mind (□ □) and the thinking spirit (□ □). It is frequently used among New Agers, in psychology and in the healthcare context in Hong Kong, to represent a dimension beyond the physical, but still of a whole being.

I would say that spirituality (*xinling* and *lingxing*), is a western term. The original Chinese understanding of *ling* or spirit is multifaceted and connotes a lot of meanings. There are different terms for *ling* or spirit using different characters and expressions that are all related to one another. The concepts are overlapping, but each is unique in its own context and usage. Because the term for spirituality in Chinese is rich, diverse and carries unique meanings in context, it can easily cause confusion and misunderstanding. This leads directly to a question about whether there are any other cultural forces that might affect the Chinese understanding of spirituality.

5.5 Traditional Chinese Medicine (TCM)

At a time when western medicine was not yet mainstream in Hong Kong, Chinese medical practitioners took care of people's health and sickness. There were also many "herbal tea stations" providing different herbal drinks for minor illnesses. To maintain health, each family would prepare special soups according to the different seasons, as advised by the Chinese medical practitioners in the Chinese herbal stores. For example, for days with "heavy humid vapor", people with "hot liver" or "cold limbs" would be prescribed special soups for removing the humidity or soothing the liver. Even now many Hong Kong citizens still consult Chinese medicine practitioners and use Chinese medicines (Chinese Medicine Council, 2017). Thus TCM is an integral part of Hong Kong culture. It continues to grow and influence people's conceptions of life and health. However, TCM is different from western medicine. There is fundamental difference between the eastern and western anthropological perspectives on the person and the world, which further confuses Hong Kong Chinese's understanding of *ling* (*xinling*, *lingxing*, spiritual/spirituality).

Since western medicine is much more developed and has become the dominant philosophy, many people consider traditional Chinese medicine, which is not evidence-based, as supplementary to western medicine. If science fails, TCM becomes something like witchcraft that can be tried without harm (Wallner, 2009). Still, in response to the over-specialization of western healthcare, there is a growing interest in eastern philosophy and TCM, in the hope of shedding new light on patients' physical and mental health (Legge, 1964; Leung, 1988; Pachuta, 1989; Hansen, 1992; Tsuei, 1992). What has happened in Hong Kong Chinese medicine, despite the dominance of western medicine? In 1995, the Hong Kong Government appointed a "Preparatory Committee on Chinese Medicine" to make recommendations to the government for the promotion, development and regulation of Chinese medicine in Hong Kong. In 1999, the Chinese Medicine Council of Hong Kong was established for implementing regulatory measures for Chinese medicine. This included registration of Chinese medicine practitioners, and the registration, safety and quality of proprietary Chinese medicines. In 2000, in a document on healthcare reform, there was a section on the incorporation of Chinese medicine into the public healthcare system. The plan included setting up Chinese medical practices in selected public hospitals and a Chinese medical clinic in each of the eighteen districts of Hong Kong. Clinical research to facilitate the development of standards and models of integration of western and Chinese medicines was proposed. Moreover, a Chinese medicine honors degree could only be achieved through full-time study at the three local universities. This was to ensure a high calibre of professional standards to support Hong Kong's development as an international center for Chinese medicine (Chinese Medical Council, 2016). Modernization, along with more evidence-based research, should be advocated in TCM practice. However, Wallner (2009), who is in the Philosophy of Science field and has conducted TCM research for more than twenty years, opines that TCM is a totally different medical model. Therefore, the modernization of TCM should not be westernization, or the adoption of the so-called scientific way of western thinking. Traditional Chinese Medicine is incompatible with western medicine in at least four respects: methodologically, ontologically, in treatment experience, and in theoretical structure. It would be of too large a scope to discuss these differences here. I will instead focus on the philosophy of TCM, the *qi* and *yin yang* concept, and argue that TCM is

different from western medicine in that there is a fundamental difference in their perspectives on human beings and the world.

5.6 Daoism, the Philosophy of Traditional Chinese Medicine

Hong Kong Chinese face a tension between a western-based holism, which is ontologically dualistic, and a TCM-based holism, which is religious. When talking about TCM, we cannot avoid the philosophy of Daoism, the main basis of Chinese medicine (Ai, 2006, Chan et al., 2006). Daoism is an ancient spiritual tradition in East Asia. Ai (2003) says that it is more a philosophy than religion, or at most a loosely organized religion. Yet following a Scottish missionary, James Legge (1815-1897), most westerners understand Daoism as a religion for Chinese just as Christianity is for westerners (Kirkland, 2012). In order to avoid homogenizing a pluralistic tradition, I would like to focus on *Taiping Jing,* dating back from the late sixth century. It is a Daoist classic (translated as the *Scripture on Great Peace*) and an example of the Chinese anthropological concept, which is holistic (Kwan, 2016). I would agree that *Taiping Jing* understands a person as a whole under the *qi* and *yin yang* concepts. It can be said that all Chinese medical physiology, pathology and treatment can eventually be reduced to these two concepts (Maciocia, 1989). Western scholars translate *Qi* as vapor, vital forces, or life energy. The concept is parallel to common English terms such as breath, energy and so on (Wu, 2013). *Taiping Jing* says that all things, including human beings, originated in the primordial vapor, *yuanqi* (□ □) which is the material essence shared by *wanwu* (□ □), everything. "The primordial vapor has three names: great *Yang*, great *Yin*, and the central harmony. Shape has three names: Heaven, Earth and Human being." When the great *Yang* takes visible shape, it becomes heaven, great *Yin* the earth, and central harmony is the human being. *Taiping Jing* further says of the human being's origin, *qi*, that "vapor produces *jing* □ (fuel for physical body), *jing* □ produces *shen* (divine

function), *shen* □ produces *ming* □ (brightness/intellect).” A Daoist philosopher *Zhuang Zho* □□ (BCE 369-286) explains the importance of *qi*, “When *qi* transforms, it becomes physical forms. When physical forms move, there is life” (*Zhangzi*, chapter 18). Another Chinese philosopher *Hu Fu Chen* □□□ explains that all cultivation methods of life for Daoism are based on training the *xing* □ or physical form (*liangxing* □□), promoting the flow of *qi* □ the life force (*xingqi* □□), and preserving the *shen* □ or spirit (*cunshen* □□). Therefore, the physical form *xing* □ or *jing* □ cannot exist without *shen* □ and nothing exists without *qi*. The “*Qi jing shen*” trio and the physical body (i.e. the shape, *xing*) form a unity and are the manifestations of the same force that gives health and life. They are not functionally interdependent nor interrelated, but are ontologically one (Kwan, 2016).

5.7 Holism of Traditional Chinese Medicine

Traditional Chinese Medicine (TCM) can be termed *Zhong Yi* literally, whereby *Yi* means medicine, and *Zhong* means Middle, or it can be referred to as the Balanced Golden Medium. *Zhong Yi* is therefore the medicine of balanced energy (Ai, 2003). Health is a harmonious equilibrium, while illness is a manifestation of disequilibrium in terms of the *qi* and *yin-yang* energy patterns. *Zhong Yi* will use “look, smell, ask, cut the way/incision” (□□□□) in early detections of *qi* stagnation in order to make diagnoses and prevent illness. The oldest existing Chinese medical text, *The Yellow Emperor’s Inner Classics*, *Huangdi Neijing* □□□□ explores the functions of *qi* extensively and explains how the quality of *qi* can affect a person’s well-being (Unschuld and Tessenow, 2011). “All diseases are affected by the *qi*. When one is furious, the qi goes upward. When one is joyful, the *qi* calms down; sad, the *qi* dissipates; afraid, *qi* goes downward. When one encounters cold, the *qi* contracts; hot, the *qi* discharges; shocked,

the *qi* is disorderly; fatigued, the *qi* is consumed; anxious, the *qi* stagnates" (*Jutong Lun*, chapter 39). Human beings therefore need to nurture their *qi* and *jing shen* in order to have health and longevity (Ai, 2006). *Qi* not only brings physical effects, but transcends human experience and existence. *Qi* is not only for an individual, but transcends the differentiation between human individuals. Good *Zhong Yi* connects the experience/ phenomena of a patient as a whole, and appreciates the uniqueness of that individual, while taking into account the dynamic interaction between a person's internal and external worlds and the circular effect within the overall unified wholeness (Tsuei, 1992; Yin et al., 1994; Chan et al., 2006).

According to TCM theory (Wu, 2013), the human being is considered a micro-cosmos. While the cosmos (heaven*, yan* and earth, *yin*) has four seasons, five elements (earth, metal, wood, water, fire), nine directions and three hundred and sixty six days in a year, humans have four limbs, five inner organs, nine orifices and three hundred and sixty six joints. In nature there is rain, wind, cold and heat. In humans, there is joy and anger. The human body is not only symbolically identified with the cosmos, it actually exhibits identical patterns and functions as the cosmos. In TCM, there are correlations between emotions, the five elements, and the processes of one *yin* organ (*zang* □) and one *yang* organ (*fu* □). For example, when *qi* goes through the heart and the endocrine, it becomes "fire *qi*". Fire is for maximum expansion and heat; and is related to joyful emotions. When *qi* goes through the kidneys and bladder, it becomes "water *qi*", which is for contraction and cold, and is about fear and sadness. When *qi* goes through spleen-pancreas and stomach, it becomes "earth *qi*". Earth *qi* is for harmonizing, nurturing and support, and is related to contemplation. "Wood *qi*" is paired with the liver and nervous system, which is for warming, expanding and growing; and is about anger. "Metal *qi*" is paired with our lungs and skin, for whatever is cooling, condensing and reflecting, and is about grief (Ai, 2003; Marin, 2006). In this sense, the heart is not only an organ that acts as a pump, but is classified as an "emperor" organ that houses the individual's spirit, or *shen,* and mental energy. Treating and improving the condition of any of the corresponding attributes can regain the *qi, yin yang* balance. When the *qi, yin yang* is in a relatively balanced pattern, vitality, harmony and integration can be produced, while

conversely, disharmonies permit pathological factors to develop. In this way, maintaining health or cultivating one's vital energy is not only the responsibility of the doctor. A person has to take responsibility for maintaining their own healthy lifestyle and harmonious attitude and for doing energy exercises called *qigong* (Ai et al., 2001). Patients are not to be referred and "divided" between clinical psychologists for emotional problems, chaplains for meaningless lives and heart specialists for burning pain in the heart due to grief. Humans are in a web of energy of different levels. One's internal balance lies in the harmonious pattern of an ever-changing *qi* in relation to the interplay at all levels of human function, one's habits and the world of life, as all life comes from the same primordial vapor. "*Yin* and *Yang* mold and cultivate myriad beings but they are all born from one *qi*" (*Daodejing*). Indeed, there can be a state when the human and cosmos become one.

5.8 Holism of the World Health Organization (WHO)

In the west, holistic care can mean a lot of different things. In the healthcare context, it is basically defined as caring for the whole patient—total patient care with four different dimensions—instead of merely relating to clinical symptoms (Livingstone, 1996). The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being, and not merely the absence of disease" (Preamble of the WHO Constitution, 1947). I would like to use WHO's concept of holism as the reference point for arguing that the perspective of holism in western medicine is a dualistic one, and is different from that of TCM.

Kwan (2016) has studied WHO's health concept extensively. The definition of health, as mentioned above, has not changed since 1947; however, there have been proposals from time to time, arising from different situations, that a spiritual dimension should be added as the fourth dimension. At the end of the last decade, under the direction of Dr. Halfdan Mahler, the WHO Director-General at that time, the executive board submitted a new definition of health to include the spiritual dimension. Although this proposal was not endorsed in the end because of an unsettled debate over whether spiritual and mental faculties were really distinct (Eto, 2004), the existence of a spiritual dimension has been fully recognized by WHO. If the revised definition had been passed, the new definition of

health would have been: “a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 1997).

Notwithstanding the above, under the advocacy of WHO, the spiritual dimension has been emphasized in the concept of holism. As early as 1984, the spiritual dimension was articulated by the World Health Assembly through resolution WHA 37.13 as follows:

> The spiritual dimension is understood to imply a phenomenon that is not material in nature but belongs to the realm of ideas, beliefs, values and ethics that have arisen in the minds and conscience of human beings, particularly ennobling ideas…. If the material component of the strategy can be provided to people, the non-material or spiritual one is something that has to arise within people and communities in keeping with their social and cultural patterns. The spiritual dimension plays a great role in motivating people’s achievement in all aspects of life.

At the 58th World Health Assembly there was a round table panel report that called on WHO members to “underline the value of including religious and spiritual dimensions in research, education, health care and rehabilitation programs” (WHO, 2005). Spirituality was fully recognized as an “essential aspect of life and health”. Under the framework of WHO holism, the complex nature of human beings is emphasized. The different dimensions are interrelated and interact dynamically. However, it is still a kind of dualism, because the spiritual dimension is understood as a non-material state that is opposed to materiality and the body. It is a distinct dimension that is in constant reaction to the physical, psycho/mental and social dimensions. This dualism can be easily explained: the birth of modern science was brought about by the formulation of a Cartesian mind/matter dualism in the seventeenth century (Ai, 1996). Biomedicine, as one of the branches of modern science, focuses primarily on the matter of body. The body is then further broken down into systems, organs, tissues, cells and molecules etc. There is a division of the material and the non-material, of the physical and the spiritual dimensions, even though both are closely related. Therefore, western holism is still a kind of dualism, while eastern holism sees a human person and the cosmos as inseparable from one *qi.* This is an ontologically different perspective on human beings and the world between west and east.

Conclusion

I have argued that there is confusion in the understanding of spirituality *(ling, xinling* and *lingxing*) among Hong Kong Chinese, because firstly, the term in Chinese is rich and connotes various meanings. Secondly, traditional Chinese medicine is a different practice and concept from western medicine. Thirdly, there is a fundamental difference between east and west in how the anthropology of a human person and the world is perceived.

Section II: Empirical Research

Chapter 6
Research Design and Methodology

Introduction

Section II records the empirical research and contains three chapters: research design and methodology (chapter 6), data analysis of three Hong Kong chaplains (chapter 7), and data analysis of three Hong Kong nurses (chapter 8). In the following paragraphs, I first link back to the theoretical perspectives that have influenced the design of my research. I then point out the gap in knowledge from my practice that the research aims to look at. I have applied Kipling's terms: the what, why, when, how, where and who, in explaining the methodology and methods of the research (Trafford, 2008).

6.1 The Knowledge Gap

In section I, I dealt with the theoretical perspectives underlying this research. The research topic is the spirituality of caregiving : with special reference to Clinical Pastoral Training in Hong Kong. In relation to the research topic, I am asking three questions: 1) what understanding of spirituality is held by Hong Kong Chinese spiritual caregivers with reference to CPT? 2) What kinds of influences might have shaped the understanding of spirituality and the practice of the caregiver? 3) How might Clinical Pastoral Training address the needs of the spiritual caregiver?

Certain features are identified as being significant to the understanding and practice of spirituality within Hong Kong Clinical Pastoral Training. Firstly, despite the fact that spirituality is a vague and diffused concept, the understanding of spirituality is important and useful in the healthcare context. Secondly, there is a confused and conflicting relationship between spirituality and religion. Because of the separation of spiritual care from its Christian pastoral care root, understanding of spirituality has become dis-

integrated and fragmented. There is a loss of identity in the spiritual caregiver. Thirdly, conflict between the two Clinical Pastoral Training fathers, Boisen and Cabot, has continued into the present and from the United States to Hong Kong. Fourthly, confusion about spirituality among Hong Kong Chinese is not only because of the varied expressions in the language, but also because of a fundamental difference between the east and the west in terms of how the anthropology of a human person and the world are perceived.

The theoretical framework that emerged from section I is that the healthcare system, Christianity, CPT and cultural factors are dynamically interrelated to shape the understanding of spirituality and the practice of Hong Kong Chinese caregivers (Fig. 6.1). Each influence contributes to the shaping process, while they are also in conflict. There is an assumption that the systems and values of the eastern culture, which are different from those of the west, have manifested the confusion about spirituality in the local context. The conflict among the different influences has caused frustration and difficulties for spiritual caregivers. It is through understanding the interaction of these four shaping influences that the practice of the training (CPT) can be enhanced to address the needs of the caregivers.

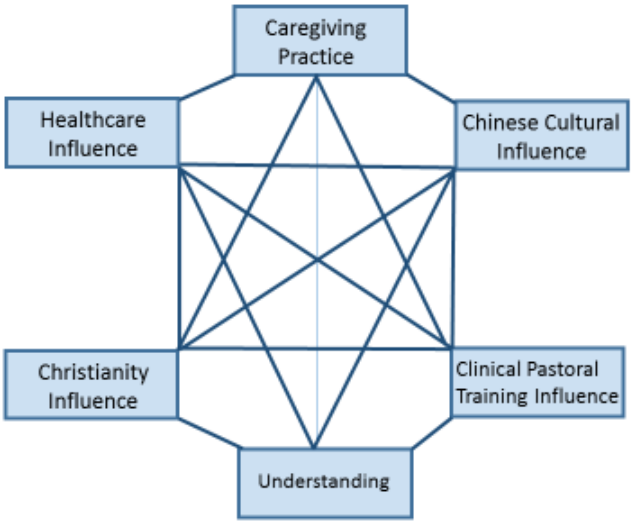

Figure 6.1 Theoretical framework of Clinical Pastoral Training activity

In section one, I drew the above notions together and provided a theoretical framework for the array of issues that make up the operational fieldwork of Clinical Pastoral Training (Robson, 1993). In the following, I explain how this framework affected my research design. I have tried to convert abstract concepts into the practical actions of planning and collecting data, in order to fill the knowledge gap.

As a CPT supervisor, and through my professional interaction with trainees, I found that they had a confused understanding of spirituality, frustration in the practice, with some even experiencing identity crises. Compared with the foreign research into spirituality within CPT, little is known about spirituality within Hong Kong Chinese culture. While there are studies seeking an understanding of spirituality from patients, there has been no research undertaken thus far with local chaplains and nurses, seeking their views on spirituality, spiritual care and their experiences in CPT, even though they are on the frontier as spiritual care providers. Although the term "spirituality" is vague and diffused, an understanding of the concept is important. Therefore, the first question I would like to ask is "What understanding of spirituality is held by Hong Kong Chinese spiritual caregivers with reference to CPT?" I may not find a universally accepted definition of spirituality and related concepts in health care. More important is reaching a clearer understanding of words about spirituality in practice, the languages in which they are situated, and the people and contexts by whom and in which they are used. This can enhance my knowledge and inform my supervisory practice.

Having been a nurse, a chaplain and now a clinical supervisor, I echo the view of most caregivers that care of people suffering from illness is a meaningful and honourable service. However, caregiving is also draining with a lot of attendant difficulty and stress. Through my professional interaction with trainees, I find that as spiritual caregivers, they have difficulties and dilemmas in practice. On the one hand, they want to evangelize because they are Christians. On the other hand, they have to abide by the rules and culture of the hospital. The conflicting relationship between spirituality and religion (Christianity) in the healthcare context leads to difficulties in practice. I have assumed that the practice of the caregiver has been shaped by the conflict between the influences of the healthcare system and Christianity. There are other influences that might have

shaped their practice also. Yet there is a knowledge gap surrounding the dynamics of the different influences, i.e., the healthcare system, Christianity, Clinical Pastoral Training and cultural factors. Therefore, the second research question I would like to ask is, "What kinds of influences might have shaped the understanding of spirituality and the practice of the caregiver?"

Having been a supervisor of Clinical Pastoral Training, CPT for some years, I can share the joys and frustrations of the trainees who serve as spiritual caregivers. In training, they are seeking understanding of the human person, of God and of caregiving. There is always a lot of anxiety and confusion within. Yet I witness their growth and the transformation in their identity and practice. Most of them reach new perspectives about the person, about God and the relationship between. I affirm that CPT is important in shaping caregivers' identities, and their understanding of spirituality and the practice of care. Today, CPT is undergoing rapid development from being a kind of theological education to professional training, and from being exclusively Christian to including other religious faiths. Conflict within CPT has continued from the days of the two CPT fathers to the present and also from the U.S. to H.K. As a supervisor, I am always thinking, "How might Clinical Pastoral Training address the needs of the spiritual caregiver?" In answering this question, I would like to obtain direction for the future development of Hong Kong CPT.

Because of the theoretical framework and the knowledge gap, my research goes from practice to theory to practice. This is an original research project with special reference to Hong Kong's Chinese context and is designed to inform my understanding of the dynamics between the healthcare system, Christianity, Clinical Pastoral Training and cultural factors, which are interrelated and interdependent in shaping the understanding and practice of spirituality. The findings will enhance my professional practice in CPT in addressing the needs of spiritual caregivers.

6.2 Research Methodology and Design

6.21 Qualitative interview

My study explores Hong Kong spiritual caregivers' understanding of spirituality and the dynamics of the different influences within Clinical Pastoral Training (CPT). It involves the complex interconnection between people's beliefs and actions. It is necessary to use a methodology that emphasizes the experiences of the participants themselves, i.e., their perspectives, actions, feelings and thoughts. Qualitative analysis is concerned with how the participants define situations. It explains the "phenomenon in terms of the meaning that people bring to them" (Denzin and Lincoln, 2000, p.3). Therefore, qualitative interviews are most appropriate for my research. I have used qualitative engagement by interviewing three nurses and three chaplains, all of whom are spiritual caregiving professionals in Hong Kong. The philosophical framework is hermeneutic phenomenology, i.e. it is both descriptive and interpretive.

Phenomenological research is descriptive, aiming to describe lived experience but does not seek to explain. My research is phenomenological as it seeks deeper understanding of the lived experience of Hong Kong Chinese caregivers within CPT. I started with concrete descriptions of their lived experiences in caregiving and used everyday language of spirituality, *xinling* and *lingxing*. I avoided any assumptions about the object of inquiry in order to understand the essence of the phenomenon. At the same time, my research is interpretive or hermeneutic phenomenology. As Heidegger said, "The meaning of phenomenological description as a method lies in interpretation" (1962, p.37).

Interpretation is inevitable and necessary in the world. When our "being in the world″ experiences a thing as something, it has already been interpreted. Gadamer (1981) even argues that human beings are by definition interpretative creatures. We understand the world through utilizing complex and continuing hermeneutical processes consciously and subconsciously. In my research, I aimed to go beyond the superficial expressions of my informants in order to access the implicit / hidden meanings and dimensions of their understanding and practice. I read through the transcripts, analyzed the descriptions and

identified some common themes. Interpretation is required to bring out the ways in which meanings occur in the context, in this case the spirituality of caregiving within CPT.

There are clearly tensions between phenomenology and hermeneutics. The former seeks to understand lived experiences in an objective and unbiased way while the latter claims that interpretation and prejudice are important to the ways in which human beings encounter the world. However, there are three similarities between them (Swinton, 2010). Firstly, both assume an 'active, intentional, construction of a social world and its meanings for reflexive human beings' (Mcleod 2001, p268). In seeking the true meaning of a phenomenon, phenomenology does not rule out the product of interpretative processes. As a researcher, I acknowledge that the facts of lived experience of my informants are always hermeneutically experienced. Moreover, as a human being, I cannot be free from the preconceptions that inevitably arise from my experiences as a nurse and a chaplain, which are also already meaningfully interpreted. Yet, measures have been taken to avoid bias and misinterpretation in order to understand the essence of the phenomenon, the spirituality of caregiving. I requested a nurse friend to independently check the transcripts, field notes and interim analyses. She acted as a third person providing feedback on my understanding, so as to provide a critical perspective. More importantly, re-check meetings were called twice with each informant to obtain validation from them. Therefore, the final product is a co-creation of the researcher and the researched.

Secondly, both phenomenology and hermeneutics "deal mainly with linguistic material, or with language-based accounts of other forms of representation" (Van Deusen-Hunsinger, 1995 cited in p.108, Swinton and Mowat). Within my qualitative research and central to the analytical task is the importance of language and text. The meaning of the different terms concerning spirituality in Chinese, *xinling* and *lingxing* were handled with great care so that they could be understood as precisely as possible. It was only in the final cycle of coding that the Chinese quotations were translated into English. During the translation process, I ensured that there was consistency in the translation of the Chinese terms into English.

Thirdly, both phenomenology and hermeneutics are concerned with the development of understanding, which is potentially transformative but not explanatory. In my study, there are three research questions. After exploring the meaning of spirituality and the kinds of influences that might have shaped the understanding and practice of the caregiver, my third research question therefore is: How CPT might address the needs of the spiritual caregiver. The understanding reached at the end aims to inform and transform my professional practice and knowledge as a CPT supervisor.

Hermeneutic phenomenology is used in my research to provide a rich description of the lived experience of Hong Kong Chinese caregivers and a necessary interpretive perspective on the dynamics of the explicit and hidden influences that might affect their caregiving. Description and interpretation are seen as a continuum. The implied contradiction is resolved as both hermeneutics and phenomenology share similar concerns as mentioned above. I acknowledge that the phenomenological lived experiences of the caregivers are always meaningfully or hermeneutically experienced. Moreover, the lived experience that has been captured in language is inevitably an interpretive process. I have taken sufficient measures and am aware of my preconceptions and the bias they introduce into interpretation.

In my study, there were two instances of one-on-one semi-structured qualitative interviews for each informant. There were some pre-determined questions, which guided me in the interviews. (The set of questions can be found in the appendices.) The questions were asked in a systematic and consistent order concerning the individuals' experiences in spirituality, caregiving practice and training (CPT). I paid attention to these structures of meaning so that I could understand the dynamics between the influences of the healthcare system, Christianity, CPT and cultural factors. I also probed beyond the answers to my prepared standardized questions. This was because different people understand the world in varying ways. Undertaking phenomenological interviews in this way is deemed most likely to elicit rich data, as the meaning of spirituality is varied, individual and sometimes abstract (Holloway and Wheeler, 1996).

During each interview, I found that my participants shared their narratives genuinely. This style of interview allowed them to relate their personal experiences freely and for

me to follow up on ideas, probe responses and investigate motives and feelings. This provided information that a written response might have concealed. It also yielded rich information that was more than simply of face value (Bell, 2006). Individual interviews were time consuming, however. Each interview lasted between one and one-and-a-half hours. The second interview was arranged after the data from the previous interview had been transcribed and organized. This was to afford an opportunity for clarification and feedback. I also called for a third follow-up session to share the data analysis result with my informants. This was for validation of my analysis and reconstruction was possible if any misunderstandings had occurred. The three interviews not only provided rich information but avoided prejudice and misrepresentation of the phenomena. Qualitative research with individual interviews does require careful preparation, effort and commitment from both participants and researcher, time to analyze the situation, much patience and considerable practice. Eventually the reward is worthwhile (Cohen, 1994).

6.22 Ethical issue

The goal of the research was to understand my interviewees' perspectives. Through explaining "the inner experiences of research subjects which can inform the practice of care", the needs of caregivers can be addressed within the CP training (Swinton, 2011, p. 105). The research is therefore not intended to damage self-esteem or be condescending. In the study, I applied the general principle of mutual respect, as suggested by both House (1990) and Sieber (1992), during the recruitment, interview, rechecking and reporting processes. All the informants joined the study on a voluntary basis after receiving my invitation. They were not my current students and had no conflicts of interest. A formal ethical permission form was signed at the first group meeting before the interviews. This gave my informants a chance to raise any questions about the meaning and implications of the research. This opportunity for "query" was granted in the whole process, for both the informants and for me. No force or manipulation was used to lead others to cooperate or to fit in with my questions. This is what Wax (1982, pp. 33-48) suggests, "Reciprocity is far more important than informed consent". However, because ethical issues often tend to be masked by the researcher's assumptions, beliefs, and values, engaging a trusted third party can be very helpful (Miles and Huberman,

1994). My research supervisors and transcriber helped me to carry out a study of good quality by raising issues I had missed, suggesting alternate viewpoints, and bringing to the surface tacit assumptions. I also requested a nurse friend to act as a third person to check independently the transcripts and gave me feedback. Last, but most important, was to obtain validation from the informants. Re-check meetings were called twice. The first time was after the first interview transcription and at the beginning of the second interview. The second time was after the data analysis of each narrative. All these were good meetings in building honest and trusting relationships with the informants, which is important for accessing and gaining knowledge (Punch, 1986, as cited by Matthew Miles, 1994, p. 292). Through the rechecking process, the informants were able to discover new aspects of their situations. This was a process of consciousness-raising. In this way, the follow-up sessions not only helped avoid misunderstanding and misinterpretation, but enhanced the worth of the study.

6.23 The cohort

Six graduates from two Clinical Pastoral Training (CPT) centers were carefully selected with the expectation that each could provide unique and rich information of value to the study (Wu et al., 2014). Six were chosen because, firstly, this was a one-person research effort. The limitations in manpower, resources and time had to be considered. Secondly, the purpose of the study was to offer a particular way of seeing and discovering, rather than to explain and solve, and thus a small sample was deemed appropriate (Moustakas 1994; Miles and Huberman, 1994; Smith 1996). Thirdly, the six informants were divided into two groups, with three nurses and three chaplains in each group. There were two sets of interviews and one follow-up session for each, which made a total of eighteen sessions in the research. This was appropriate for the one-person research, yet was able to yield rich information for new discovery.

The six informants were in two groups. One group was three nurses, while the other group was three chaplains. I set some criteria for choosing the right informants. I considered that gender was not an issue. Most important was that the nurse or the chaplain had to have finished at least one unit of Clinical Pastoral Training. The training could not have been more than two years before the interview to ensure freshness of

memory. The nurses and the chaplains also needed related clinical experience for at least two years and must remain in the profession during the interviews. The process of finding the right informants was more difficult than I expected. It was not easy to find the right nurses. In Hong Kong, CPT is not a credited training for the nursing profession. They all shared with me that they really had to persist in order to finish the training in a single year.

My six informants were nurses and chaplains and all Christians, because Hong Kong Clinical Pastoral Training is currently only open to Christians. These two types of caregivers were chosen for three reasons. Firstly, they were all frontline healthcare providers who expected to provide spiritual care in Hong Kong. I assumed the gap and tension they experienced between the healthcare system and Christianity would be considerable. Secondly, nurses are regarded as a typical healthcare group, while chaplains are atypical in healthcare in the matters of training, behavior and characteristics. This kind of maximum variance is commonly used in qualitative research and I felt different perspectives might help me gain deep understanding for my study (Sandelowski, 1995). Thirdly, as one group of informants was strong in medical background, while the other was strong in theological background, comparison of the two groups could yield rich information on the differences and the similarities.

There were some limitations to my research. The three nurses all came from the same training center, while the three chaplains are now working in the same hospital. This might explain some of the similar experiences the nurses had in Clinical Pastoral Training and similar struggles the chaplains had in their caregiving. Moreover, the number of finished CPT units varied among the six informants. Some had completed all four units of CPT, while some had completed only one unit. There was one who could not distinguish clearly the first CPT experience from the other units as she continued the training in one unit immediately after the previous unit.

6.24 Data collection

Before the individual interviews, I invited all the informants to a briefing group meeting. The meeting served to explain formally the reason I wanted to interview them, the purpose of the study, to welcome them and to express thankfulness. Before any ethical

permission form was signed, a clear explanation was given about the focus of the research, how the data would be collected, how confidentiality would be protected, their participation in the data analysis, and the role of the seminary where I was working. This was to make sure the informants were able to understand their rights and my responsibilities (Bell, 2006). I found that this briefing group meeting in the form of a social chat with snacks was useful for ice-breaking. The warm and respectful climate that was created not only allowed them to meet one another, it also helped to develop a sense of togetherness as a group so as to encourage continuation of individual participation in the research. Each interview was later on carried out in the counseling room in my teaching seminary, as the recording facilities were built-in and there was no need for extra technical support. All the interviews were recorded and then transcribed. This was to create "a text which becomes the locus of the interpretive process" (Swinton & Mowat, 2011, p. 117).

6.25 Data Analysis

Data collection and analysis was an ongoing and simultaneous process. I hired someone to transcribe my interviews. This eased my burden and also helped to save time from my daily work. The interview was originally in Chinese and the data entry was also in Chinese. This was to ensure that the meaning of the different terms concerning spirituality in Chinese, *xinling* and *lingxing,* could be precisely understood. It was only in the final cycle of coding that the Chinese quotation was translated into English. During the translation process, I ensured there was consistency of the translation of the Chinese terms into English.

There were three cycles in my data analysis. In the first cycle, I read through the interview transcription several times and immersed myself in the text, including individual phrases, sentences, and even single words. I interwove my reflections in the margins of the interview transcript. In the second cycle of coding, the informants' concepts of spirituality, spiritual care and their experiences in Clinical Pastoral Training (CPT) were extracted and organized into different meaningful units. I used the computer program Excel to help me store, sort and retrieve the data in the second cycle of coding. In the third cycle, as a beginning qualitative researcher, I applied mainly the "In Vivo

Coding" together with "Versus Coding" and "Structural Coding" (Saldana, 2013, pp. 103-135). Concepts and direct terms from the informants were drawn and labelled as codes. I then compared the codes, and based on the differences and similarities, I grouped them into categories and sub-categories. A category can be a theme, a pattern, a finding, or an answer to a sub-question of the research questions. Finally, the codes, the categories and sub-categories were organized as tables in each piece of the data analysis. In the table, I used capital letters to represent the order number of each category and sub-category, i.e. A, B, C… and the sub-categories as A1, A2, A3 and B1, B2, B3...etc.

According to Miles and Huberman (1994), once most data are analyzed and themes categorized, noting the patterns and clusterings is an important technique for verification and validation. My challenge was to construct categories or themes that captured some recurring patterns. The patterns reflected the dynamics of the different shaping influences that might not have been obvious on the surface. These patterns also cut across both sets of data, one from interviewing the chaplains and one from the nurses. I had to immerse myself totally into the narratives, as they were sacred texts. This is what Gerkin (1984) would hold: applying the methods of biblical hermeneutics in understanding human experiences which are assumed to be sacred. I tried my best to understand the interviewees' ways of characterizing spirituality and the dynamics of shaping influences they might not have been aware of. The whole process was interesting, yet consumed a lot of time. I considered the follow-up session important. This was because it was my informants' validation and trust that carried me through. Their comments and thoughts were always my consideration. The resulting product was therefore one of co-creation, whereby the researcher and the informants embarked upon a quest for meaning and understanding of the notions of spirituality. Supervision by my supervisors was then the light to direct me when I was struggled in the long and dark tunnel of data analysis and study.

This chapter has shown how the literature in the previous section first determined the direction of my research and influenced the research design. I have explained the way I planned and conducted the field study, so to fill the knowledge gap. During the data collecting process, the findings in return informed me and helped me develop my

thinking about the theoretical portion. When I was writing, the findings helped me in constructing the theoretical framework. Therefore, the presentation of the literature review in section one, although it might seem deterministic in the research, was attained through a process of dialogue between my understanding of the literature and the data analysis, coding comparison and theme grouping.

The research design enabled me to connect my purpose of study to the data collection process and thence to my supervisory practice in the Clinical Pastoral Training. This was a one-person research study totally from practice to theory to practice. The research has been conducted within its limitations. Further studies are needed in the understanding of other kinds of influences and the meaning of spirituality. Yet, the objectivity and validity of the original research was ensured by good research methodology and design.

Chapter 7

Narratives of Three Hong Kong Chaplains

Introduction

In the previous chapter on methodology and research design, I explained how the research design was aimed at helping me to address the research questions: What is the understanding of spirituality of Hong Kong Chinese spiritual caregivers within Clinical Pastoral Training? What influences might have shaped their understanding, and in turn their practice? How might Clinical Pastoral Training might address their needs? This chapter is about three chaplains' narratives. Each narrative is structured in relation to the following six headings:

(1) Background information
(2) Understanding of spirituality
(3) Spiritual care practice model
(4) Clinical Pastoral Training experience
(5) Difficulties in the practice
(6) Resolving the conflict

Using the above categories, I show how the research questions are answered directly or indirectly. The information is mainly from each person's reflections about the days when they joined Clinical Pastoral Training, transcriptions of the focus group interview, transcriptions of individual interviews and the personal reflection note written by the researcher during and after the interview. In the discussion text, coding of direct quotes is put inside quotation marks and capital letters are used to number the categories.

7.1 The Phenomenological World of PW

Background information

PW is a chaplain about forty years of age. She graduated with a Bachelor of Christian Education and Christian Counselling (BCC) from a seminary school. Before studying theology, she was a counsellor in a Christian organization. In order to learn more about counselling, she joined the seminary without knowing that this was the only seminary in Hong Kong that offered Clinical Pastoral Training. At that time, she had no idea about the role and the requirements of being a chaplain. I met her in the seminary when she and her friend wanted to know what Clinical Pastoral Training (CPT) actually was. They were not sure whether to choose CPT as one of their elective courses. In her last year of study, she joined CPT as a one-year extensive program coached by another supervisor. After graduating with a BCC, she joined a one-year CPT residency program at Hong Kong Hospital Christian Chaplaincy Ministry (HKHCCM). She completed all four units of CPT before starting work as a chaplain. She reflected that this was a result of the step-by-step guidance of God. As a first step, she had accompanied her father and mother-in-law who were sick and who died within two years. Then she worked with people as a counsellor. Afterwards, without knowing that there was CPT at the seminary, she entered the only one that offered this training and finished CPT unit by unit. She reflected that all these experiences were relevant and seemingly unplanned, but were a kind of life preparation with God's guidance. God had been waiting for her and let her choose the time she was ready to take up the calling. At the time of the interview she had been working as a chaplain for three years. She was working as a full-time chaplain with Shatin Chaplaincy Limited, which offers spiritual care service for hospitals in the Sha Tin area. PW worked with palliative care unit patients at Bradbury Hospital, and in the pediatric unit and medical and cardio-thoracic surgery units at Prince of Wales hospital.

PW was the last person I interviewed. I met PW two times and each time for between one-and-a-half and two hours. There are a total of 115 codes and 21 categories derived from the transcripts. The relationships between the categories are described in the following paragraph and illustrated as Figure 7.1.

PW has her own understanding of *xinling* care and *lingxing* care and the definitions of religion and non-religion. An understanding of Christianity in relation to the above

sounded confusing to her. Christianity is sometimes religion and sometimes not. The confused understandings about spirituality brings a dilemma in her practice. In the diagram, I have used red boxes to show PW's confusion in her understanding and practice, within Christianity, and her role and identity. Clinical Pastoral Training has been a positive influence for her, for when she undertook CPT, she found her identity, calling and her role as a chaplain. The helpful elements in CPT helped her a lot. Her being and her intention in caregiving were shaped by her understanding of God, which gradually grew in CPT. In caregiving, PW's main concern is to address the needs of patients and relatives. Different patients have different needs and there are differences between palliative care and pediatrics care. Different skills are needed in caring. PW showed a kind of confusion about the role of a chaplain in relation to the role of nurse. She could discern the distinct role of a nurse, but not the definite role of a chaplain. On the one hand, she regarded herself as a pastor for healthcare professionals. On the other hand, she did not really understand them. As PW said, she was still learning about the relationship between nurse and chaplain.

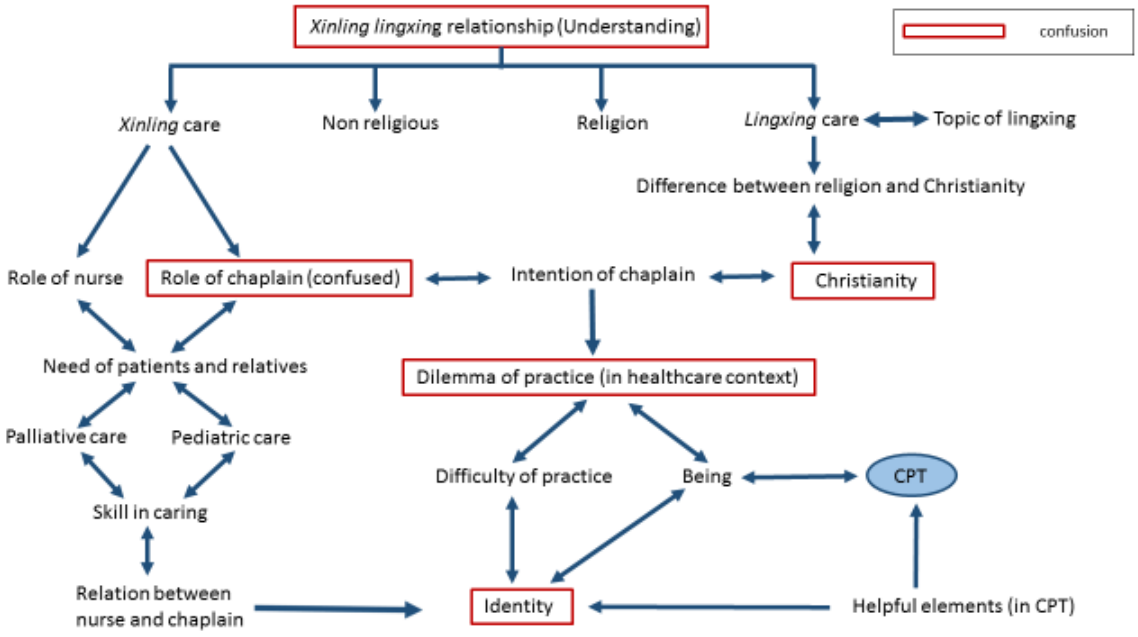

Figure 7.1 Relationship between the 21 categories derived from 115 codes

Understanding of spirituality

When I interviewed PW and asked her about her understanding of spirituality, she shared with a kind of confident understanding that spirituality was about the heart. She considered there was no difference between *xinling* or *lingxing* spirituality, just that they were two expressions for the same thing. However, the term sounded diffused to her. Spirituality, *xinling* and *lingxing* connoted at least three different kinds of meanings.

A1 Spirituality*, xinling lingxing*, "is heart" and is life. They are the same.

a. Life—a person or self. It is about the "value of a person" with a kind of "self-understanding". As PW quoted from Genesis, this was a living person with spirit after God breathes in the spirit. Therefore, this person has spiritual needs. In difficulties, a person can reflect about their self-relationship with illness. It is also about different kinds of feelings like hope and peace.

b. Life—this includes beliefs about life, "meaning of life", "life and death understanding", life control and life questioning. It is about whether there is a creator in life, or whether life is determined by fate or by luck.

A2 Spirituality is about the needs of a person. This need as a person is universal whether s/he is religious or not. There are some differences between delivering *xinling* care and *lingxing* care. The differences are insignificant however, as long as the needs of a person are addressed.

a. Emotional needs, including need for company, worries need to be listened to, the need to grieve, need for space, children's need to be happy.

b. The understanding of life—PW admitted that when she can share with patients about faith and life, it is a deeper level of care, and is *lingxing* care.

"*Lingxing* care is probably deeper. If I can share with them a bit more about faith, or I can help them to understand the meaning of the problems they are facing and their adversity in illness, it is probably *lingxing* care" (S14).

A3 Spirituality has a kind of relationship with religion and "faith" in Christianity. However, in relation to religion and Christian faith, spirituality, *xinling lingxing*, becomes confusing because each term has different connotations.

a. "*Lingxing* is related closer with faith"—faith is a special term in Christianity for PW. This faith is not only that God is the creator who breathes spirit into a man. There is a kind of relationship between the human person and God. Therefore, Christianity is also about "living out the faith", the meaning of life in faith, and seeking the creator and responding here and now. Religion, on the other hand, "is not about the relationship between the self and the world". It is "philosophy", and it "is understanding and explaining life experience". In this way, *lingxing* is closer to Christian faith than it is to other religions. However, *lingxing* also sometimes refers to other religions, and not only to Christian faith.

"When it is about life or the meaning of life, it is *lingxing*. When *lingxing* is about life, it is not necessarily from the perspective of the Christian faith. All religions have *lingxing* concerns. Though different religions have their own understandings of life, they all seek to address this concern" (S2).

b. "*Xinling* is a broader term than faith"—*xinling* here includes Christianity, other religions and people without religion. Here *xinling* includes *lingxing,* because the *topics of lingxing* include religion, death, hope and peace.

"Buddhism, Taoism or others are religions, i.e. they are philosophy and not faith, or maybe they are faith. Maybe for Buddhists and Taoists, it is faith for them. However, my understanding is not like this….Yet during the sharing process, I am packing and repacking. I reflect that maybe I am wrong in my concept" (S11).

I would say that for PW, the terms *xinling* and *lingxing* connote different meanings in relation to religion and Christian faith. This confused understanding of spirituality is not only because there are two terms to express the concept. The relationships between spirituality, religion and Christian faith are themselves confusing.

Spiritual care practice model

PW regards herself as a healthcare professional. Therefore, though she has the intention of sharing her faith with patients, she has to abide by the rules of the hospital for *xinling* care, which is about being together, respecting choices and addressing patients' needs. On the one hand, she sees her chaplaincy role of *linxing* care as guidance in faith, praying with patients and reading the Bible etc. On the other hand, the care has to address patients' needs accordingly. We can see that the healthcare influence and the theological influence are competing with each other inside her. How might this affect her practice? In

the structural code of *xinling* care, PW's values, beliefs and attitudes in the practice are illustrated as follows:

Value: address the need—spiritual care has to be delivered according to the needs of patients and relatives, which can differ between the palliative care unit, pediatric ward and for dying patients.

Belief: together—spiritual care is about "keeping company", "experiencing together", "walking together" and "listening to patients' needs". In order to be together, another belief in PW's *xinling* care is "I have to be healthy".

Attitude: choice—in delivering spiritual care, giving choice to and respecting the choice of the patients are both important.

With these values, beliefs and attitudes in *xinling* care, the process coding 42-46 can be illustrated as the psycho-spiritual care practice model for PW as follows. Psychological skills are the focus of the spiritual care practice in order to address the needs of the person.

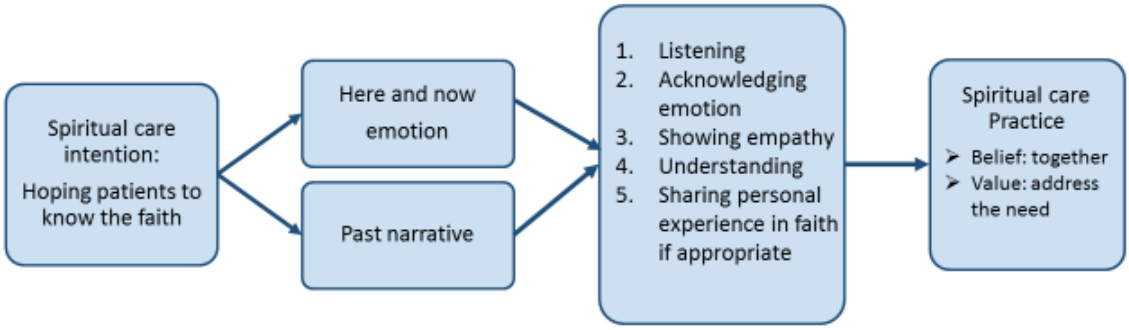

Figure 7.2 Psycho-spiritual care practice model

Clinical Pastoral Training experience

PW considered CPT very beneficial in at least three respects. Firstly, she found her calling to be a chaplain during the training. She reflected that her past experience was God's preparation for her to serve as a chaplain. Her experiences during the units let her understand "God's calling and guidance" such that she finally responded "to the calling".

T1 CPT and experiencing God

T1a Life experience as preparation
T1b God makes the way
T1c God waiting for me

Secondly, the experiences with God in CPT brought about a change in her identity. Although she considered that she was "not good enough" to be a pastor, God still waited for her. She had the freedom to choose whether or not to face her own pain and whether or not to accept advice from supervisors. As she said, God let her take her time until she could accept her pastoral identity.

T2 CPT and identity

T2a God's confirmation of identity
T2b God's healing
T2C God works in me

Thirdly, PW agreed that the interactive small group relationships among peers and supervisors were very helpful for her. The openness of peers in IPR (inter-personal relations) became her encouragement to face her own life issues. The interactive relationships co-created among members allowed them to share genuinely and they experienced a kind of emotional release and a sense of relief.

T3 CPT and helpful elements

T3a Small group learning
T3b Theological reflection
T3c Didactic

PW concluded her CPT experience as follows: "Through CPT, God showed me that I have to face my own pain so that I can be responsive to His calling. The training helped me to deal with my own life issues. It helped me to confirm my pastoral identity so that I can serve in God" (I1S42).

Difficulties in practice

PW works as a chaplain and has to face difficulties, including with the ministry and the self. She considers that her role as a chaplain, apart from attending to patients, is also about "pastoring healthcare professionals". Her ministerial difficulties therefore include, "I don't understand the healthcare professional" and "I am still learning to establish a pastoral relationship". I would say that the difficulties are due to an identity confusion. Chaplaincy care is *lingxing* care, which is supposed to be on a deep level, but PW cannot find much difference between the *xinling* spiritual care provided by her as a chaplain and that provided by a nurse. While the chaplain is supposed to be a pastor, she is not clear about her role. There is a dualistic role inside her. There is confusion between her pastoral identity and her healthcare professional identity. The healthcare and theological forces conflict with each other and are manifested in the relationship between nurse and chaplain.

Relationship between nurse and chaplain

1. "Co-operate with the healthcare people as a whole team in the palliative ward"
2. Different resources of nurse and chaplain as a spiritual care provider

   2.2 Nurses are quick to respond to physical needs
   2.3 Chaplains address the "long term" needs of patients

3. Not much difference in the *xinling* care provided

   3.1 *Xinling* care is company and walking together, listening to patient
   3.2 When the nurse also has CPT
   3.3 The nurse also is spending time with patient in need
   3.4 Nurses sometimes pray

4. Confused identity in the role of chaplain

   4.1 PW considered that responding to physical need was the focus of nursing care. Yet there was "no special focus" in her chaplaincy care. She mentioned that "My focus is *lingxing* care, that is, care to address the patients' needs".
   4.2 "I don't know" the work of nurse
   4.3 "I am not clear" about the time they can spare with patients
   4.4 "I don't know" whether nurses can pray or not

The difficulties a chaplain faces are due to an identity confusion. This chaplain does not find her care distinctive. I would say that this confusing identity is because of a confusion in the understanding of spirituality, *xinling* and *lingxing.* There is a gap in the practice that manifests itself in the dilemma between a practice that is "clear" vs. practice that is "confused" vs. patients' needs.

"From my time of study, the concept of spirituality (*xinling* or/and *lingxing*) is clear. However, when I started practicing in the wards, caring for different kinds of patients, I probably got confused. I am not certain enough to tell what spirituality is. I am not certain whether there are differences between each of the concepts. I just get in touch with patients and care for them according to their needs" (I1S3).

Resolving the conflict

Listening to PW's narrative, I could tell that there were difficulties for her as a chaplain and that there was confusion in her identity. She was also facing some personal struggles at the time of interview. I wondered what made PW remain in the service. Towards the end of the interview, I asked PW her reasons for joining CPT in the first instance. To my surprise, she shared with me a long story about her "calling". After that, I reflected in a note that most of the parts of the story were irrelevant to my research questions, but must have been very important for her. At the time I listened attentively without much interruption, as I do feel honored when people share with me their spiritual journey with God. Afterwards, when I read over the transcriptions and the coding repeatedly, I found that PW had answered my research questions indirectly. For the theme, the being of chaplain, I found "depending on God", working together with God, "experience together with others" and being "responsive to the calling". The crisis in her identity and the difficulties in ministry are somehow resolved through her calling. PW experienced God's calling during her CPT, as mentioned before. In the training, there was a change in her being. This self-being was "not good enough" and the role of this self as a chaplain was "not clear". However, through God's confirmation of her identity she can continue to "experience together with others" and "work together with God".

PW's faith in Christianity is very important to her. It has shaped her understanding of God and the understanding of the person, who is "a living person with spirit". The

spiritual needs of a person, therefore include "seeking the creator" and "responding" to Him in various life experiences, especially in times of difficulty and illness. Spirituality in Christianity conflicts with spirituality in the healthcare context and has brought about identity confusion for PW. Yet, PW's spirituality has taken her through the difficulties. PW's spiritual journey is about establishing a personal relationship with God. This personal God heals and works together with PW in everyday life through adversity. PW has to respond continuously to God's calling of love. At the end, PW concluded in her chaplaincy spiritual narrative, "I feel deeply that I am not the one who does it and it is not a matter of what I have done. Being is more important. God has worked in me through all the experiences so that I can practically respond to His calling" (S42).

Healthcare and theological forces have both shaped PW's understanding of spirituality and her practice. The two terms, *xinling* and *lingxing* spirituality, sound confusing to her. The complicated relationships between spirituality, religion and Christian faith confuse her further. The forces conflict with each other, leading to a confusion in her identity. In CPT, PW found her calling and confirmed her pastoral identity. In facing difficulties in the caregiving service, the being and spirituality of a chaplain are important to her. This, for PW, is her personal and continuing relationship with God day by day in the practice.

7.2 The Phenomenological World of SY

Background information

SY is single and about forty years old. She is a chaplain and lives with her family. Before studying in seminary school, she worked as a social worker. In her last year of study for the Bachelor in Christian Education and Christian Counselling (BCC), she took her first Clinical Pastoral Training unit as an elective course. At that time, she did not know anything about CPT. All she knew was that there would be clinical attachment in the training. She was looking for a place to practice her counselling skills. Caring for patients in the hospital is "similar to counselling". Therefore, she joined CPT. SY shared with me another reason for joining the training: she hoped to find the answer to her spiritual inquiry at that time. There was a time when she was praying and saw a picture of a hand

stretching out for help from the rough sea. Then she saw a hand from heaven reaching out to that hand. The picture meant "salvation" to her. She reflected that during difficulties in her life, she would seek help from Jesus. However, the special meaning of that particular vision remained unclear. Later, when the training started, she realized that it was God "calling" her to the training. The hospital she was attached to was the same hospital where she had previously been a volunteer for more than ten years. She met the same chaplain with whom she had worked closely. She had served there for a long time and only left the volunteer service when she became sick. SY had forgotten about this part of her life until the day she found herself back in the hospital for CPT. This experience was "amazing". It was as if it had been arranged for her to go back to the same hospital and meet the same chaplain. All this brought back her memories of her life of nearly sixteen years before.

I was SY's CPT supervisor in her first unit. She discovered her calling to be a chaplain during the unit. After she graduated from seminary school, she started her chaplaincy service in Prince of Wales Hospital. She was the first one in the office who held a Bachelor in Christian Education and Christian Counselling (BCC), but not a Bachelor of Theology (BTH) or Master of Divinity (MDIV). At the time of the interview, she had been in the service for five years. She was studying for her MDIV, which was requested by the chaplaincy office. Currently, she mainly works with medically chronic patients.

I know SY personally. She shares with me naturally and genuinely every time we meet. There are 148 codes and 21 categories derived from the transcripts of chaplain SY. These are summarized in the text and illustrated as Figure 7.3 as follows:

As a chaplain, SY considers chaplaincy service to be walking together with patients. The practice is not easy because of the confused understandings of spirituality, *xinling, lingxing* and the relationship between them. The confusion and dilemma in practice are illustrated as red rectangles in the diagram. Her values and beliefs in caregiving have been shaped by Christianity and the healthcare system. However, as a Christian, she has found a gap between the theory and practice. The confusion within Christianity causes disintegration within the self. There are also conflicts between healthcare and Christianity. The conflicting relationship is illustrated as a dotted line in the diagram. SY joined CPT

and found her CPT experience important. She not only found her calling as a chaplain, she also experienced personal growth through the inter-personal relations, individual supervision and the trusting group relationships. In facing all the difficulties in practice, SY considers that she is also a person with needs. The health of the being, a home for rest, and reflection space to increase self-awareness are crucial for her in effecting a healthy practice.

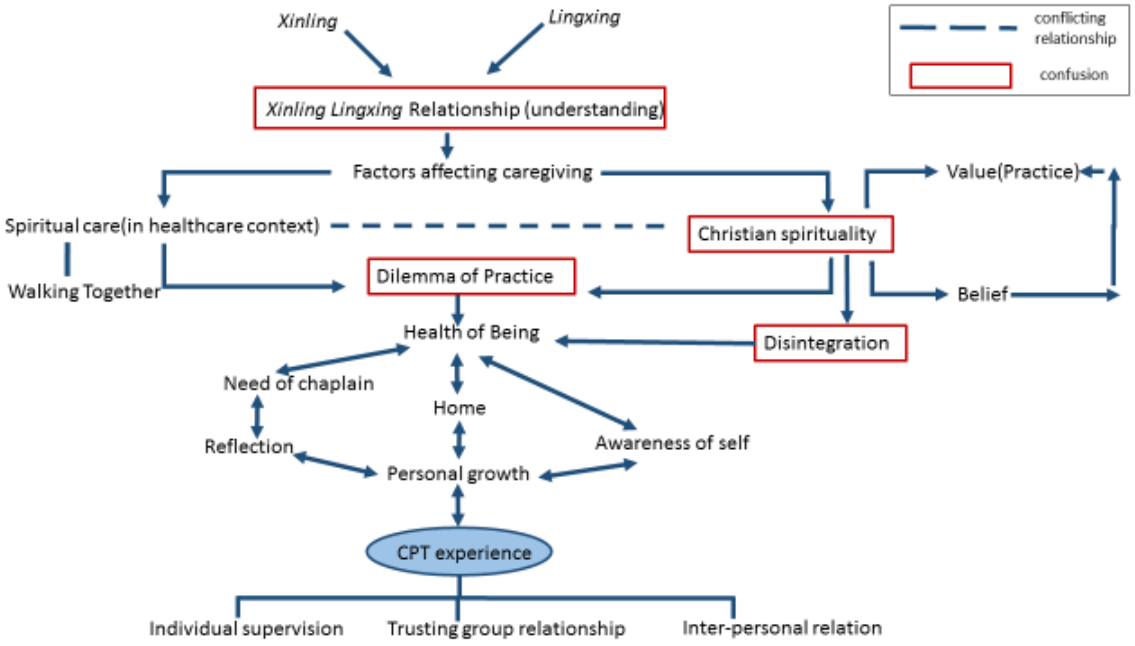

Figure 7.3 Relationship between the 21 categories derived from 148 codes

Understanding of spirituality

In SY's mind, *xinling, lingxing* and spirituality should be the same. However, she frankly admitted that she was "confused" about the understanding. She was confused because firstly, there are two terms in the expression. Each term seems to carry different meanings and has been used differently. The differences are illustrated in the table as follows:

M *Xinling lingxing* related

Ma *Xinling lingxing* different:

	Xinling	*Lingxing*
Ma1	"*Xinling* is broader, not only one part"	"*Lingxing* is one part of the four dimension"
Ma2	"*Xinling* is physio-psycho-social-spiritual"	"*Lingxing* is relationship with one God"

Ma3	"*Xinling* is more holistic"	"*Lingxing* is religious"
		"About meditation, bible, prayer"

Secondly, there is confusion in SY's understanding of spirituality because the two terms connote the same meaning in terms of the needs of a person.

Mb *Xinling lingxing* the same

Mb1 Emotional need
Mb2 Need of others
Mb3 Universal and individual need

	Mb1 Emotional Need	Mb2 Need of others	Mb3 Universal
Lingxing	Being understood	"It is life" connecting togetherness	"Need of individual can be different"
Xinling	Worries need to be shared	Need of company Need to be helped	Universal need

Thirdly, the confused understanding of spirituality is because of the confused relationship between spirituality and Christianity. On one hand, Christianity is a religion which "is some beliefs". On the other hand, Christianity is *lingxing,* which is "life", "togetherness" and "relationship". There is a conflict between her phenomenological healthcare world and her Christian religious world.

Mc *Xinling lingxing* confusion

Mc1 I am confused
Mc2 I am disintegrated within
Mc3 I don't know how to make it clear

Christian Religious World	Phenomenological Healthcare World
"Religion is some beliefs"	*Lingxing* "is not only set of beliefs"
"*Lingxing* from church is disintegrated"	Health is holistic
"About meditation, bible, prayer"	*Lingxing* "is life" connecting

SY explained her understanding of spirituality as follows:

"When people (in the church) mentioned *lingxing,* they did not care about the psychological aspect of a person…. It is this concept formed in the church which makes me confused…. I realized more and more that a person is whole and when health is concerned, it requires the concern and care of all the dimensions of a person. If we just care for the *lingxing* part and neglect the others, this [spiritual caring] does not work" (I2S14-17).

Spiritual care practice model

Beliefs, values and attitude of spiritual care

SY was a social worker with a strong counselling background. Before any involvement in spiritual care, she thought that spiritual care was similar to counselling. At the time of the interview, she agreed that in personal connection, walking together and a kind of empathetic understanding are similar. Yet she also emphasized their differences. The distinction of spiritual care is that it is the encounter of two equal subjects. SY used a real life narrative to illustrate the concept of the subject. It is coded as "I have difficulties", "I am helpless", "I am a human with needs". How can this weak caregiver provide spiritual care? This is answered by her beliefs about practice. Spiritual care is "not human work but God's work". Her beliefs about spiritual care can be grouped as God's work and human need. Under the umbrella of God, the caregiver and the cared-for are two equal subjects, each with his/her own needs. They can establish "interacting personal relationships" and "walk through together". Her beliefs about spiritual care have been shaped mainly by Christianity. This is illustrated in Figure 7.4, showing the relationship between SY's beliefs and her caregiving practice. Her beliefs have been shaped by the God in Christianity. Under God, the spiritual caregiver and patient are equal.

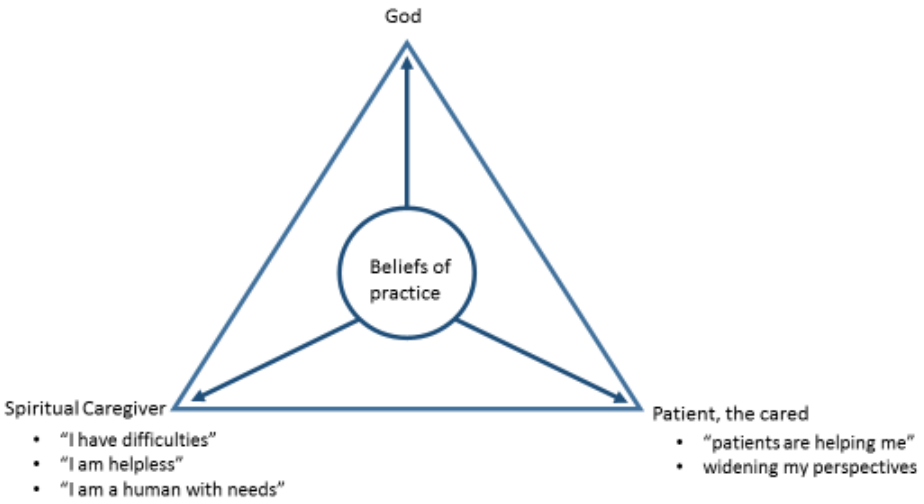

Figure 7.4 Christian influence shaping the beliefs about practice

SY sees spiritual care as the encounter between two equal subjects. Her values concerning practice include "love", "respect" and "holistic". This is understandable, as she is an honorary spiritual care staff member in the hospital, serving non-religious patients or patients from different religions. Her "ultimate purpose to bless" is the attitude that guides her along in the practice. In the structural code, her dilemma of practice is the "intention to evangelize". I would say that the Christian influence has shaped her beliefs, while the healthcare influence has shaped her values. Sometimes there is competition between the two influences. "To bless" becomes the mediator between them.

The competition between the healthcare and theological forces is manifested in SY's spiritual care practice model as illustrated in Figure 7.5. It is a kind of "two-tool connecting practice model". For SY, spiritual care is "walking together"; her tools are her psychological skills. These include listening, empathy and other communication skills. Spiritual care is also "*lingxing*" care, which is "connecting". As a caregiver, SY connects with God, having an "authentic relationship with God". She is then able to accept her "uniqueness" and "connect with self" before she is "free to connect" with others. Her tool is theological reflection. For SY, theological reflection is represented as follows:

K1 Reflection of Self:

Enhance self-understanding, Holy Spirit working within me

K2 Reflection of the Practice

Action / Reflection

K3 Reflection through Relationship

K3a Relationship with God
K3b Through personal relationship

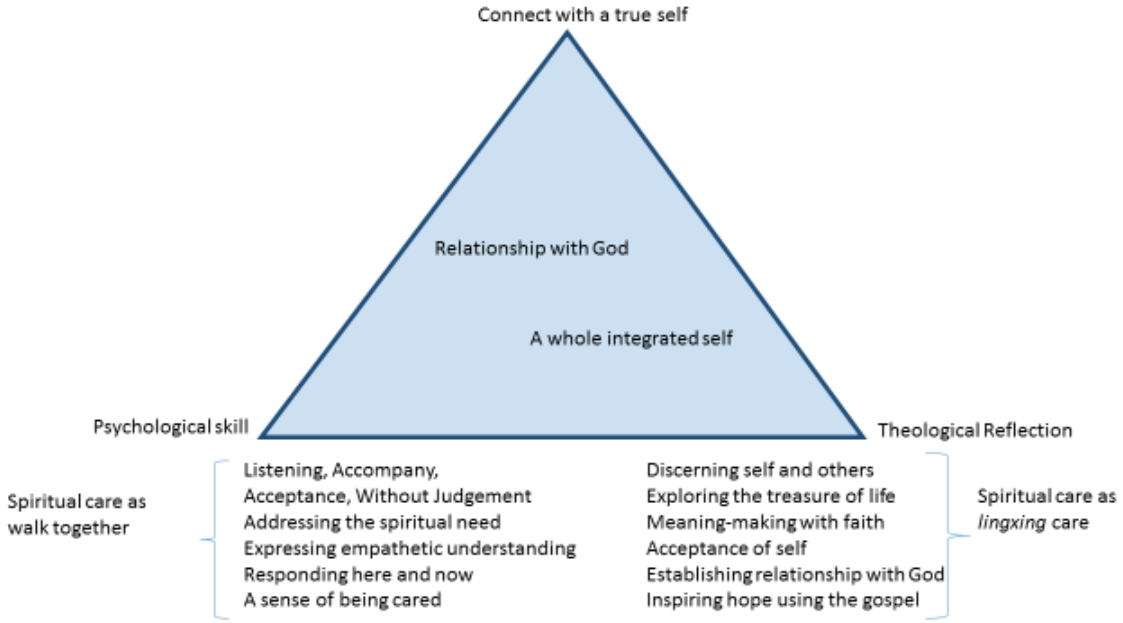

Figure 7.5 Two-tool connecting spiritual care practice model

For SY, a whole integrated being is important for both the caregiver and the cared-for. Her task in spiritual care includes helping patients to see and find the self and meaning in life. The caregiver has to inspire hope, to encourage and always be available. Both psychological skills and theological reflections work together in her practice. There is a special remark in my reflection journal from after our first interview. SY found her service a blessing and a privilege. With an elevated tone and a satisfied smile, she said: “I can feel the wonder of the Holy Spirit. It works in me through the process…. This is a dynamic and interactive [working] process in which I can understand myself more. It is

really a blessing to be a chaplain. It is not only helpful and beneficial to others. It is an advantage to me. There is no service like this" (I1S28).

Clinical Pastoral Training experience

CPT is a small group and interpersonal learning process. Participants learn about spiritual care through action/reflection. They also learn through the different relationships established during the training, including those with different group members, the supervisor, different healthcare personnel, chaplains, patients, relatives and other authoritative figures. SY agreed that the small group design, reflection through practice, and learning through different relationships enhanced her understanding of God, self and others. Her experiences in CPT can be represented in the following sub-themes.

A1 CPT and relationship

A1a: Self — "self understanding", new perspective of self, enhance self confidence, "stepping out from comfort zone", "discerning self and other"
A1b: Other—sense of security, encourage genuine expression, "enhance understanding of patient", mutual acceptance, feel supported
A1C: God — "understanding God and self", "wonderful preparation"

A2 CPT helpful elements

A2a: Trusting group relationship
A2b: IPR (interpersonal relation) — "reflection to enhance self understanding", "enhance openness", "personal growth stepping stone"
A2c: Individual supervision

A3 CPT for integration

In the structural code, disintegration is "care" vs. "gospel", "skill" vs. "self", and "share to inspire" vs. "teach to preach". SY is "disintegrated within". She commented, "At that time (CPT), I was learning. There was one part in me for caring. There was another part for the gospel. It made me feel awkward…. CPT provided a platform for integration…. The most important thing is that I have to be integrated within as a whole person" (I1S21-23).

A4 CPT and Reflection

In CPT, SY learned to reflect. She sees reflection as a way of exploring the treasure of life. Because of the reminder of Holy Spirit, integration of the self is possible.

K1 Reflection > Holy Spirit > a whole integrated self
K2 Reflection > faith> to live out the special self in Jesus in life

As a conclusion to the CPT experience, SY said, "I value reflection in CPT. There is good and bad in life. They are all treasures. We need to do deep reflection to enhance self-understanding and understanding of life. Reflection helps me to explore and integrate my own life. It helps me to live out the faith. It helps me to live out the special me in Jesus" (I1S42).

Difficulties in practice

In the first interview, I found that SY saw her service as a blessing. Her tools are also helpful in her practice. At the beginning of the second interview, I asked SY what might make her feel frustrated in the practice. In the structural code, dilemma of practice is "share" vs. "choice," which leads to disintegration of "care" vs. "gospel". I consider that her frustration is because, firstly, the theological force and the healthcare force are sometimes in conflict. On the one hand she would like to share the gospel, on the other, she does not want to and cannot "hard sell". She is an honorary staff member in the hospital and has to respect the choices of patients. On one hand, she has to care for and address the spiritual needs of the patients. On the other, she wants the cared-for to find their authentic selves in a special relationship with God such as she has. The structural code for disintegration is represented as follows:

J1: Disintegration—conflicting theological force and healthcare force

- J1a: "Care" vs. "gospel"
- J1b: "Skill" vs. "self"
- J1c: "Gospel" vs. "daily life"
- J1d: "Share to inspire" vs. "teach to preach"

Secondly, frustration arises because there is confusion in the understanding of spirituality in her religious world. At the end of the interview, the time had already overrun. I thought everything had been covered. In a token way, I asked SY if there was anything I

had left out that she wanted to add. She shared with me her reflections about studying theology at that time. In the remarks in my diary, I was “surprised”. The time spent was already longer than I had promised, yet she still wanted to share. I was “confused”. The topic was irrelevant to our interest. What was the reason for her sharing at that particular moment? My gut feeling told me that it was important. Now, after reading her narrative again and again, I would say that there is disintegration within her religious world. On the one hand, theology is a very important force in shaping her beliefs and understanding of spirituality. This was illustrated in the previous session. However, her spirituality in relation to the church is disintegrated. Moreover, there are conflicting perspectives on spirituality in Christianity. Within the religion itself, she “doesn’t know” and what she “used to” know can be a “pre-supposition”. The various beliefs about spirituality in Christianity cause different understandings, which can in turn lead to conflict in the practice.

J2: Disintegration-- within her religious world

J2a: “Meaning making in faith” vs. “cannot understand”
J2b: “Faith” vs. “living out”
J2c: “Help” vs. “hinder”
J2d: “Experience” vs. “practice”

For SY, the difficulties in practice are from the disintegration within her. The disintegration is because of the confused understandings about spirituality within Christianity. There are also differences between the understandings of spiritual care in SY’s healthcare world and in her religious world.

As a conclusion, SY said, “The set of theological beliefs sometimes help and sometimes hinder our connection with others. It is about different understandings of God and people, which we do not really understand. In history, different theologians have had different perspectives… For me, I am used to the set of beliefs taught by the church. I accept it as the truth though I do not know where it comes from. There are different views about spirituality and spiritual care in Christianity. These may influence our understandings, which in turn become our presuppositions when we have arguments about this topic. In daily practice, I have to be open. Understanding and acceptance is important” (I2S55).

Resolving the conflict

For SY, there is a dilemma in practice and there is disintegration within the self. She finds her service a blessing, but at the same time it "is not easy to sustain" (I2S46). Without a "healthy *xinling*", she cannot serve as a spiritual caregiver. The structural code factors affecting the practice and needs of the chaplain can be further categorized as follows:

R1 Need > Healthy *xinling* > Healthy Practice

R1a Physical—"sleeping", "jogging"
R1b Psychological—"sharing" vs. "doing", "individual supervision"
R1c Social—interacting relationship in church, need others' prayer
R1d Spiritual—"personal relationship with God", "understanding God"

R2 Home > Healthy *xinling* > Healthy Practice

R2a Home—place of security, "resting place", "sense of belonging"
R2b Family— "family gathering empower", "strength", "to care and be cared"

For SY, a whole and healthy integrated self is the best resource for sustaining the dilemma and the conflict in spiritual care practice. Home and family is the source of rest, peace and strength. I would say that this is typical of Chinese culture, which emphasizes family a great deal. In my reflection diary I remark that, "I am surprised" by the strength and peace that family can give her. The need and understanding of SY as a whole integrated self cannot be separated from her Chinese culture.

"When my family members, young and old gather together, I feel empowered. Maybe there are things that I have to take care of which sometimes make me worry, but the life with my family is precious. I am not only serving the needs of others. I am also concerned with the needs of my family members too….When I am back home, I can rest. I feel safe and secure. Maybe it is because we are on good terms now. Therefore, although my mom is sometimes long-winded and I have to take care of some of the family burdens, the relationship with my family gives me a kind of power. It gives me strength. That is very important for my healthy *xinling*" (I2S48-50).

There is confusion in SY's understanding of spirituality. There is conflict between her religious world and her healthcare world, which is manifested in her two-tool spiritual

care practice model. For SY, a whole integrated healthy self is the core of her service. The understanding of this self cannot be separated from Christianity, which is a kind of relational spirituality within her Chinese culture.

7.3 The Phenomenological World of MF

Background information

MF is a chaplain aged over fifty. She had not thought of becoming a chaplain until she found her calling in her first unit of Clinical Pastoral Training in 2012-13, which was a one-year extensive training program. At that time, she was in her last year of studying for the Bachelor of Christian Education and Christian Counselling (BCC). CPT was an elective course of her program at seminary school. Before she started, she knew nothing about CPT. She asked some of her friends and everyone told her that it was a good and special experience. It was "related to life" and they had gained a lot from the course. As MF did not have many courses to finish in her last year, she decided to take the course. I got to know MF because I was one of the supervisors at the seminary, although she was not in my group. I met her only in the didactic lectures we had four times a year, when all the groups in our seminary would gather together.

Having graduated from BCC, MF then joined a one-year CPT residency program at Hong Kong Hospital Christian Chaplaincy Ministry (HKHCCM). She finished her next three units in that year. She shared that she had a new supervisor in each unit. She found it beneficial and there was a common characteristic among them. They all showed her "continuing care" with love when different crises happened during those periods of training. Their care not only sustained her throughout the crises, it also became an important role model for her own spiritual care practice later on. In the year of residency, she did her attachment with Sha Tin Chaplaincy Limited. In 2014, the year she completed all four CPT units, she started working as a chaplain for the chaplaincy company. The chaplaincy company is responsible for spiritual care in hospitals of the Sha Tin region including Prince of Wales, Bradbury, Cheshire and Sha Tin Convalescent Hospital. At the time of the interview, MF was studying part-time for her Master of Divinity (MDiv.)

which was requested by the chaplaincy office. She had worked as a chaplain for about two years under the same chaplaincy. She is now currently working with patients in the palliative care unit and in the general wards at Sha Tin Convalescent Hospital.

There are 207 codes and 19 categories derived from MF's transcripts. These are summarized and illustrated in Figure 7.6. There was a confusion about spiritual care and *xinling lingxing* in her understanding. The confusion was so great that MF used the English term "spiritual" instead of the Chinese terms. As a chaplain caregiver, MF also had a confused role, a dilemma of practice, and a confused identity, which are illustrated as red boxes in the diagram. The confused understanding had a direct relationship to the difficulties in practice and identity crisis. CPT acted as a positive influence in MF's life as she had some *xinling* needs of her own because of the hurt in her life (family abuse) and church conflict, MF joined CPT and found her identity as a chaplain. Her beliefs about self and her relationship with God were transformed in CPT. MF still meets challenges in her daily task. She considers that the satisfaction from care and other resources enhance her practice and carry her through all the difficulties and struggles in her caregiving role of chaplain.

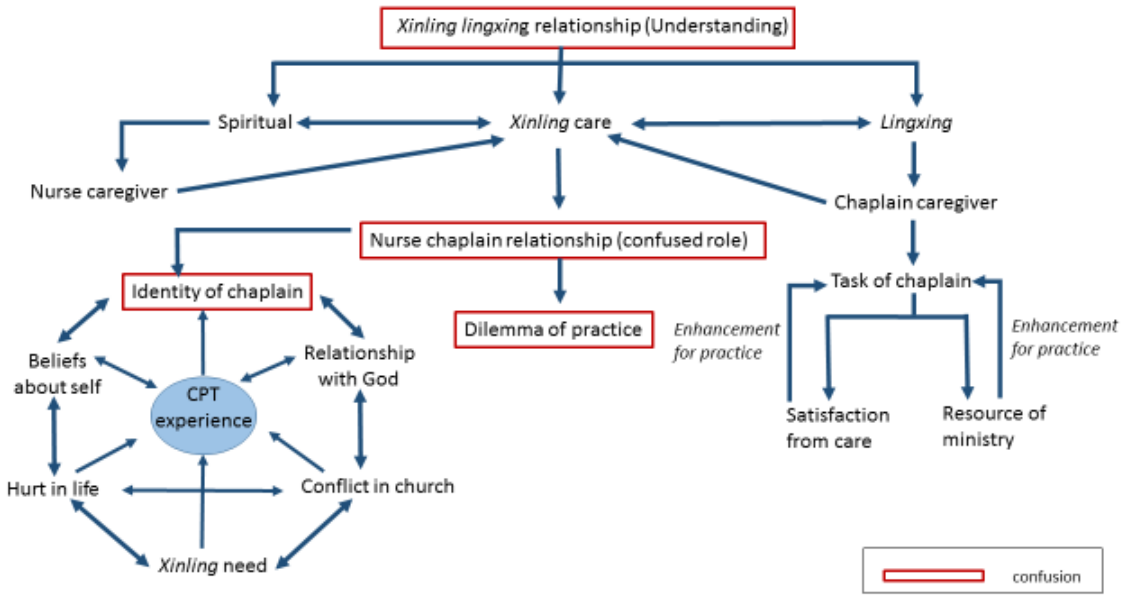

Figure 7.6 Relationship between the 19 categories derived from 207 codes

Understanding of spirituality

There are three terms to express spirituality for MF, namely, *lingxing, xinling* and spiritual. For MF, on the one hand, each term connotes a specific meaning in itself. For example, *xinling* is often used together with care and need. On the other hand, the three terms all have a similar confused relationship with religion. Religion is faith, which is Christianity in MF's context. Sometimes the three terms are related to faith, sometimes they are not. The relationship of spirituality and faith has confused her understanding of spirituality. This is illustrated in the table as follows:

	Related to Faith	NOT Related to Faith
F *Lingxing*	Fa1 "*lingxing* associates with faith" Fa2 Christianity church, gospel, filled by God Ultimate purpose of *xinling* care is " *lingxing* is faith"	Fb1" *lingxing* is not faith" Fb2 Emotion concern, worry, feeling, hope
D *Xinling* associated with care and need	Da1 " *xinling* support is not only faith" Da2 Christianity forgiven and accepted by God, Confess, God's love	Db1 *"xinling* needs are not related to faith" Db2 holistic physio-psycho-social-spiritual
I Spirituality	"include religion and other"	"may or may not be related to Christian faith"

Table 7.1 *Xinling, lingxing* and spirituality in relation to faith

I would say that there is a confusion in the MF's understanding of spirituality, because the relationship between Christianity and spirituality in the healthcare context are sometimes in conflict with one other.

The second reason for MF's confusion is because of the confused relationships between the three terms. Spiritual is sometimes *xinling,* and used in the "hospital more", sometimes it is "*lingxing* needs" which is "deeper than *xinling*". In the *xinling lingxing* relationship, *xinling* and *lingxing* are on the one hand related to each other, with *xinling* on "top" and *lingxing* "down" a bit. On the other hand, they are described as "two" parts. Spirituality within the healthcare context is expressed in these three terms for MF. Their

varying uses lead to confusion. The relationships between them are in conflict. The following is a table showing the relationships:

	xinling	*lingxing*
I Spirituality	Ia1 " *xinling* in hospital more" Ia2 Person perspectives, expectation, resource, forgiveness, individually different, "deepest needs to be satisfied"	Ib1 "is *linxing* needs" Ib2 Person peace unfinished business Ib3 "deeper than *xinling* the superficial level dimension"
J *Xinling lingxing* relationship	Ja"two" parts Jb two levels Jb1 *xinling* on "top" level Jb2 *lingxing* "down"a bit	

Table 7.2 Relation between *xinling, lingxing* and spirituality

Whether it is *xinling, lingxing* or spirituality, MF has described them in terms of levels. For example, a "higher level of *lingxing* relates more to faith", *xinling* is a bit deeper than the "superficial level dimension" and *lingxing* is "deeper than *xinling*". There is a "top" level and a "down" level. This levelled understanding of spirituality is manifested in the "step by step, level by level" *xinling* care.

"We (as chaplains) do not only care about the spiritual, because by doing so we will only care for a part of the whole. There are the physical, psychological, social and spiritual dimensions. We have to explore each dimension on its own level and position so as to understand the patient's need" (S2S1).

Spiritual care practice model

MF shared with me in detail the steps she takes in providing *xinling* care. There are five different levels where she will "walk together" with patients slowly and gradually. She makes assessments from time to time to determine whether she should go deeper or if she should delay the depth in caring. The assessment index includes the physio-psycho-social

appropriateness of the patient's condition, the relationship between the chaplain and the patient, and whether the patient is willing to accept blessing and prayer from the chaplain. The structural code for the *xinling* care process is illustrated in the diagram as the "Level and Step Spiritual Care Practice Model" in Figure 7.7 below. The *xinling* care process of different levels is guided by MF's beliefs, values and attitudes.

E *Xinling* care process

Eb1 Belief: "patients' need centered", "God's servant to care"
Eb2 Value: "walk together", "respecting choice", "peace from God"
Eb3 Attitude: "continuing love"

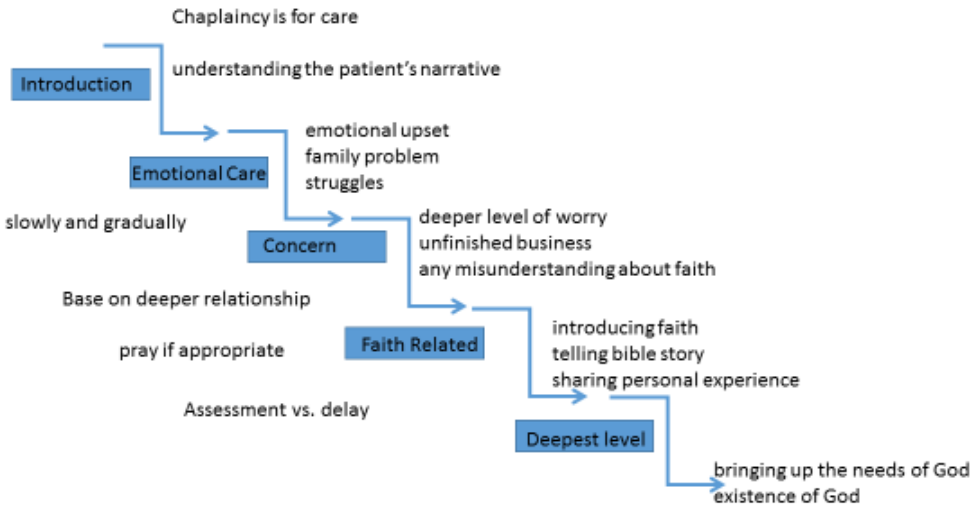

Figure 7.7 Level and step spiritual care practice model

MF used some narratives to describe her spiritual care practice. I put down in my reflection journal after the interview: "Unexpectedly cautious and careful practice". I wondered where this caution came from. When I read over her transcript again and again, I found that there was a conflict between her Christian and healthcare worlds. On the one hand, MF's identity as a chaplain was: "care with God's love" and "faith cannot be left out". On the other hand, as an honorary staff member, she has to be "patients' need centered" and "respect choice". These two shaping forces are in conflict and she has to be cautious in the practice. Moreover, her *Chiu Chau* Chinese family background has also

shaped her understanding of spirituality and informed her step/level spiritual care practice model.

When MF shared her narratives, I was surprised to find that she had so much hurt in life during her first unit of CPT. She had abuse in her family, she was "being rejected in church" and she was angry with God. Yet she remained silent and "tolerated" the abuse. She told me that the beliefs in her culture affected her reaction at that time. There is a strong sense of hierarchy in the *Chiu Chow* Chinese family. The male figure or the father has the highest position in the family. Children have to listen and follow. Her *Chiu Chau* culture also told her that "a woman has no say" and "knows nothing". A separated family is shameful and it is the responsibility of the woman to hold the family together as a unit. Therefore, she described herself as having a "low self-image".

Her parents understood her situation of being abused, but advised her to be understanding and "tolerate" her husband. As a daughter, even though MF was a grown up with her own ideas, she still followed the advice of her parents and continued to tolerate more than she wanted. She continued to submit to her husband in the abuse. She believed that she could not leave her husband and had to hold the family together no matter what.

I would say that MF's "level by level, step by step" spiritual care practice is due to a conflict between Christianity and the shaping force of the healthcare system. At the same time, it cannot be separated from her cultural background, which distinguishes and confines members in the family, male and female, to different positions and levels.

MF described her role as a chaplain in caring as follows: "I show care step by step and gradually. I see what the patient's need is. This includes the physical condition. I consider other conditions to assess the appropriateness as well. If s/he cannot talk that much, or if s/he has too many worries, I talk with the patient about faith/*lingxing* spirituality a bit later. I talk about other subjects. Then I ask whether the patient wants prayer. If s/he can accept prayer and is not likely to resist, I will say blessings for his/her health…Seeing how deep our relationship can go, I then explore faith. I introduce *lingxing* spirituality gradually" (I2S10).

Clinical Pastoral Training experience

MF finished four units of CPT to complete her training. She met four different supervisors with four groups of trainees in each unit. She found that doing theological reflection, didactics, and keeping confidentiality in groups, were all useful in her training. However, the most important aspect was her experiences with her peer group and supervisor. With special reference to the first unit, CPT gave her firstly, a sense of togetherness. Her peers and supervisor "accepted" MF with "encouragement", "love" and "continuing care", which shaped her values and attitudes towards *xinling* care later on. As mentioned before, her *xinling* care value is: walking together and her attitude is "continuing love". The structural code of CPT experience is illustrated as follows:

A CPT experience

A1 Sense of togetherness

A1a Peer Group: "crying together", "willing to walk together", "interactive" relationship
A2b Supervisor: "love", "continuing care", "understand my need"

The second experience MF had in CPT was a kind of *xinling* care from her CPT group. The sense of togetherness she had with her peers and supervisor met her *xinling* need. MF had many hurts in life during her first unit of CPT. As she said, she had a lot of *xinling* need, including the need to be listened to and understood, the need to share and need of "prayer". In CPT, the way her *xinling* needs were cared for allowed a new relationship with God. This also shaped her understanding and practice of *xinling* care as a chaplain later. This includes genuine presence, accompany, connecting and "no God, no life, no care".

A2 CPT experience: caring and being cared for

A2a Peer Group: "treating me gracefully" > God's presence> continuing love
A2b Supervisor: "supervisory guide" > experiencing God's love > "without God, my care is limited"

Thirdly, MF described CPT as a self-discovery process. Her hurt was healed when her *xinling* need was met through a sense of togetherness with her peers and supervisor. The

experience showed God's grace towards her. Her attitudes of a "low self-image", and "I don't know my need", and "I know nothing" changed. She felt secure in the group. She increased in self-awareness. Instead of believing that she had a "destined" life, she believed that she "could do it". She found that she had "resources", was able to "express" herself, was "willing to open" and became transformed.

A3 CPT experience: transformation of self

A3a Discovery of one's Effort in CPT: "willing to open", "secured to express", "I have to risk myself"
A3b Acceptance of Self: "face the problem", "self-acceptance", God is here vs. hurt
A3c New Discovery: "wider perspectives", "I have resources", identity of chaplain

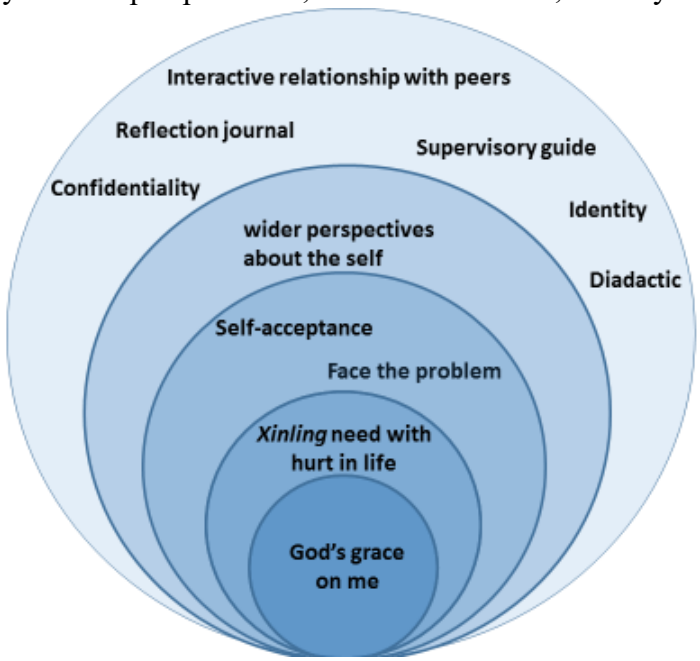

Figure 7.8 Transformation of the self in CPT

Difficulties in the practice

MF found her calling and her identity as chaplain in CPT. She found her clear identity as a chaplain who "cares with God's love". The ultimate purpose of her *xinling* care is "*lingxing* is faith". Therefore, in her practice, "faith cannot be left out". She admitted that there are struggles in the practice, because of the conflict between her Christian faith and healthcare shaping influences. These have been discussed before. The challenges to her identity increase when there are similarities between the *xinling* care provided by the nurse and chaplain. For example, they are "similar if she is Christian nurse" and if the

nurse is experienced and skillful enough to listen. Christian nurses may also "share *lingxing* faith" with patients. Yet MF finds that a chaplain has a clear identity. She has a clear role of "guidance" to patients, attending to "relatives" and is "flexible". There is a clear task of the chaplain to let the patients experience God's love, to "arouse the need of God" and to "preach the gospel if appropriate".

In practice, MF frankly admitted that she has a fear of caring for male patients who show rejection. She illustrated this dilemma of practice by sharing a real experience. On the one hand, she felt rejected by a certain male patient; on the other, she had to show continuing care. Even if she got "no response" from the patient, she had to show and treat each patient equally by continuing to visit. After some time, the patient thanked her for her continuing concern. I would say that the dilemma in MF is normal when a person feels rejected by others. Yet an understanding of her fear towards males who reject her cannot be separated from the *Chiu Chau* Chinese cultural influence which has shaped her beliefs and self identity.

Near the end of interview, MF said that there is a great need for caring for patients in the hospital. The demand for care can be sudden as the conditions of patients are unpredictable and their needs might keep changing. The demand is so great that she experiences "guilt" when she cannot meet all the needs. Yet, she "enjoys experiencing together" with patients. This brings her satisfaction from caring. There is still a dilemma of practice, caring vs. gospel, and gospel sharing is left to the last moment rather than at the start. Yet this is balanced by her clearly transformed identity and her careful step by step practice. She has found resources within her to resolve the dilemma.

<u>Resolving the conflict</u>

MF has a clear identity as a chaplain with a clear role and task. This self-identity affects her understanding about caregiving. Both become an important resource and with other factors can enhance MF's practice.

K Resource of ministry

Ka Identity of a chaplain
Ka1: "I work for God"
Ka2: "Strength from God"

Ka3: “God works within my intuition”

Kb Understanding of caregiving
Kb1: “God is in control”
Kb2: “God’s grace”
Kb3: “God prepares the coincidence”

Kc Enhancement for practice
Kc1: “Self-understanding”
Kc2: “Group”
Kc3: “Continuing education”
Kc4: “Reflection time”
Kc5: Supervisory “reminder”

As a conclusion MF said,

“If I depend on myself, I will burn out very quickly. I realize more and more that my caregiving is God’s grace through His reminder. God works with me. I cannot work on my own. There are many things happening in the ward every day. I cannot control and serve according to my plan….Caregiving is about a kind of awareness of His presence. Whatever I do, how much I can do is from the strength that God gives me, i.e., grace….There are a lot of patients, a lot of needs in the ward. I have to accept my limitations. I have to rest instead of serving at every moment. I am important too. As God’s servant, I have to take good care of myself. This kind of self-understanding is different from before” (I2S62-65).

There is a dilemma in MF’s practice. This is due to confusion in her understanding of spirituality and spiritual care, which has been shaped by Christianity, healthcare influences and Chinese *Chiu Chau* cultural forces. MF has experienced transformation in CPT. There has been a change in her beliefs about the self. Her newly-formed identity from God has taken her through the difficulties in caregiving and has become her resource in the service.

7.4 General Discussion of the Three Chaplains

Thus far, the narrative of each chaplain has answered the research questions directly and indirectly. The following paragraphs constitute an overall discussion about the chaplains' understanding of spirituality and the kinds of influences that might have shaped their understanding and practice.

While I was working as a chaplain, I met a patient who asked me the reason for becoming a chaplain. From her understanding of our service, chaplaincy caregiving is draining, because chaplains have to listen to a lot of sad stories. For the patient, this was not work that most people would like to do. I agree that it is not easy at all to be a chaplain. It is well known that caregivers like pastors can easily burn out and experience compassion fatigue. I would also add that for religious caregivers, the conflict within the religious world, herewith Christianity, cannot be ignored as one of the reasons for the fatigue, for it can bring disintegration within the person and dilemma in the practice. Working as religious persons in the healthcare service, chaplains find themselves caught in the conflict between healthcare and Christian influences. From the chaplains' various narratives, this conflict is so severe that it challenges the selves and identities of the caregivers, leading to confusion and frustration.

7.41 Understanding of *lingxing* spirituality among the chaplains

There is a confused understanding of spirituality among the chaplains. All their understandings of spirituality are closely tied to Christianity, which is expressed as *lingxing*. I will therefore take *lingxing* spirituality as the basis for discussion of this group. Their understanding of spirituality is analyzed from their cognitive understanding and is reflected in their practice.

Firstly, spirituality is not just any word. For these chaplains, spirituality has a meaning rooted in Christianity. They all consider that *lingxing* spirituality is "associated with faith". It is "closer", and is from church. Spirituality or *lingxing* is suggestive of Christianity. As many theologians have cautioned, spirituality is a lost word because it has been detached from its Christian root. I consider that this phenomenon is reflected in the confused understanding of spirituality among this group. On the one hand, *lingxing* is

deeply rooted in Christianity, as experienced by the three chaplains; on the other hand, it is separate from Christianity in the healthcare context.

Secondly, all of them consider that *lingxing* spirituality is about the person (or self, or fate). When it is about the person, spirituality is the value and needs of a person. From the perspective of their spiritual care practice, themes of spirituality about the person include love, choice, respect, connection, togetherness. It is also about the holism of a person and is universal for all persons.

Thirdly, *lingxing* spirituality is about God. There are, however, variations between the chaplains when it comes to their understanding of God. PW's understanding of God focuses on the personality of God. God is the creator and the spirit who guides and leads. For SY, God is associated with relationship, meditation, prayer and the Bible. Meanwhile, MF's understanding about God is about the gospel or preaching the gospel. There is thus a varied understanding of God within Christianity, as exemplified through the three chaplains.

The confusion within Christianity not only affects their understanding of spirituality and God. The gap between their Christian world and their phenomenological worlds causes frustration in their practice. On the one hand, Christianity is about faith and the preaching of it is clear. On the other hand, Christian beliefs are confusing and "cannot be understood" in daily life. SY, as a chaplain or religious person, considers that there is a gap between Christianity as a religion, and as a faith when it is lived out. She wonders whether Christianity actually helps or hinders. The conflict among Christians results in judgement and loss at church, which has hurt MF. PW also finds that Christianity confuses her. On the one hand, it is about the institution and is associated with philosophy. On the other hand, it is life. The teachings from church might not be able to help her provide caregiving in line with her patients' needs in life. This conflict within Christianity is manifested as a conflict at church for MF, as disintegration for SY and as a dilemma of practice for PW.

Fourthly, *lingxing* spirituality is relationship. Relationship is a sub-theme of *lingxing* spirituality about the person and about God. SY's "two-tool connecting spiritual care practice model" is based on an "authentic relationship with God" so that she can have a

relationship with the self, that is, “connect with self” and in turn have a relationship with others, i.e., be “free to connect with others”. PW’s “psycho-spiritual care practice model” is built on togetherness. This is a kind of relationship building between the caregiver and the cared-for that involves keeping company, experiencing, walking and listening. The foundation of PW’s Christian faith is also the establishment of a personal relationship with God. MF’s relationship with God, being influenced by the *Chiu Chow* culture, is a kind of hierarchical relationship. She is God’s servant and cares with “God’s grace”. In her “level and step spiritual care practice model”, her task as a chaplain is to restore the relationship between the person and God. This is accomplished by her “step and level caring” with assessments from time to time. The assessment includes the patient’s physio-psycho-social condition and the kind of relationship that has been built between the chaplain and the patient.

For all three chaplains, spirituality is relationship. This relationship includes the relationship with God, which cannot be separated from the relationship with others and with the self. The relationship between persons and with God is so closely tied together that the health of either dimension can affect the health and whole being of a person.

Despite the fact that the three chaplains are confused by the two terms for spirituality, as well as by the conflict within Christianity, their understanding of spirituality as *linxing* is deeply rooted in Christianity and carries a powerful set of meanings for them. Their understanding also affects their practice. Therefore, I consider that the understanding of spirituality as *linxing* is important in the healthcare context.

7.42 Conflict between the healthcare context and Christianity

In each chaplain’s narrative, the shaping influences of healthcare and Christianity compete with each other in different ways. I consider that the influences of healthcare and Christianity are in conflict for the three chaplains. This conflict challenges the selves of the chaplains as caregivers as well as their practices. The conflict is strong enough to cause pastoral identity confusion, disintegration within the self and dilemmas of practice.

The healthcare system and Christian influences are both important in shaping the identity, the beliefs, the attitudes and values of the three chaplains’ practice. However, the two

influences are in so much conflict that they challenges the self and identity of the caregiver. God is an important and common theme in the lives of the three chaplains. Without God's calling and confirmation of identity, PW would not have remained in the service. SY believes that caregiving is God's work, while MF considers that she is God's servant and says that, "without God, my care is limited". Therefore, it is natural that the intention or task of the three chaplains is to have God-talk with patients: "arousing the need of God" (MF, code 190), "inspiring hope using the gospel" (SY, code 63) and "sharing with faith" (PW, code 36). However, as they are all honorary staff members in the hospital, the need of patients is the common priority in their caregiving. For PW, her "focus of *lingxing* care is addressing the need" (87). MF's belief about caregiving is "patients' need centered" (112), while SY would emphasize spiritual care as addressing spiritual need (58) as the "need of individuals can be different" (85). On the one hand, all three chaplains want to talk or do something related to God (about God) in caring. On the other hand, this can conflict with the need to respect the choices of a person. I consider that what was once the chaplain's clear pastoral role of being like a shepherd caring for the life and welfare of the flock, has changed. The role has turned into an unclear matter of spiritual care that is about the person. The separation of spirituality (*lingxing*) from its Christian root has manifested itself as a conflict in the identities of the chaplains.

The conflict between these dualistic roles cannot be neglected in understanding the needs of spiritual caregivers. PW sees herself a pastor. As a pastor, her intention is "hoping patients get to know the faith" and delivering the faith accordingly. However, she does not have the confidence to do so, because what she has learnt cannot help her in practice. Moreover, she sees herself as the pastor of healthcare professionals. Yet, she "is not clear" and "doesn't know" the nurses. She cannot distinguish her pastoral caregiving from nursing spiritual caregiving if the nurse is also a Christian who prays with patients and also has CPT. For her part, SY clearly admits that as a chaplain, she would like to share the gospel. However, she does not want to be and cannot be too "hard sell". The conflict is so great that there is disintegration within her. MF shared with me that she always struggles in deciding when and how to proceed from one level of caring to another, and one step of caring to another, in her "level and step" caregiving model. When I shared my analysis of her practice model with her, MF began to realize that this

has contributed to her abnormally long time sleeping after work, which her family has complained about. The conflict between the healthcare and Christianity influences is so great that she has always struggled with the dilemma. This struggling in everyday practice makes her very tired, not to mention affecting the other duties that she has to fulfill in caregiving.

There is clearly a conflict between the healthcare system and Christian shaping influences. This is a conflict about God and about the person, about the pastoral role and the spiritual healthcare staff role. All three chaplains would like to evangelize or engage more with patients in sharing about God. Yet, they are caught in the conflict. The conflict is so strong that it challenges self, identity and practice. This is illustrated in table 7.3 below.

	Conflict of the two shaping influences	Manifestation
PW	N relationship between nurse and chaplain Na Confused Identity in the Role of Chaplain Na1: "No special focus" Na2: "I don't know" Na3: "I am not clear" Nb not much difference in *xinling* care provided Nb1: Nurse can pray Nb2: Nurse has CPT	Pastoral identity confusion
SY	J disintegration Ja: "Care" vs. "gospel" Jb: "Share to inspire" vs. "teach to preach" Jc: "Skill" vs. "self"	Disintegration within the self
MF	M dilemma of practice Ma: "Caring" vs. "gospel" Mb: "Starting" vs. "last moment" Mc: "Guilt" vs. "limitation" Md: Need of others vs. need of self	Struggling self in dilemma of practice

Table 7.3 Conflict between healthcare and Christian influences and its manifestation

7.43 Culture shaping influence

As mentioned above, for the three chaplains, spirituality is about the person, about God and about the relationship between the person and God. The self or the being is an important common sub-theme of spirituality. For example, PW's spirituality is about self-understanding and self-image. SY's spiritual care is about walking together with patients

with a true self. SY considers that in the process of caregiving, both the cared-for and the caregiver can find the self. For MF, a new discovery of the self in return brings transformation in the person-to-person relationship, person-to-God relationship and the relationship within the self. The three chaplains all find that understanding of the self cannot be separated from the understanding of God and others. This self is always in relation to God and to others. Concerning their own selves, firstly, they all admit that as caregivers, the self has needs. Secondly, the needs of the self have to be addressed to maintain a healthy practice. Thirdly, the needs of the self are often in conflict with the needs of others. Fourthly, the differentiation of one self from other selves is important, i.e., an increased self-understanding, self-awareness and self-discovery is important in the practice.

From the three chaplains' narratives, the self of the caregiver relates positively and directly with the caregiving practice. That is to say, a healthy self can lead to a healthy practice. An increased understanding of the self enhances the understanding of others and God and can enhance the practice. It is only in PW's narrative that I cannot find the impact of culture in shaping the self. Both MF and SY find that their Chinese family culture is important in shaping the health and image of the self. MF finds her own voice unimportant as she is a woman with a low position within her family. Her relationship with her self is poor because of this "low self-image". Her hierarchical *Chiu Chau* culture has also shaped her as "God's servant". She remains submissive even when she feels angry. In her relationships with others, because of a low self-identity, she responded passively when faced with the unfair judgement from her church. When her CPT peers "treated her gracefully", she was moved by the relationships. The cultural influence has shaped MF's self-image and its importance has been manifested in her life crises. For example, she continued to stay with her abusive husband. She felt shamed even though she was the one being abused. For SY, the family home is her "resting place" and gives her a sense of "belongingness" and security. Family is a place of "gathering" for her. SY admits that the family home may not always be perfect. Her mother is "long-winded" and the home has "burdens and worries" that SY has "to take care of". However, the persons and the relationship with her family can empower and offer her "strength". Therefore family is an important resource for nurturing a whole integrated self. A whole integrated

self is the key to SY's spirituality and practice. I consider that the Chinese family culture is subtle but important in shaping the self of the caregiver.

Culture naturally integrates itself into the life and family of a person. In understanding the self of a person, the role of the family is significant. I would add that the understanding of the cultural background, which provides a whole picture of the self, is especially important to Chinese. Chinese culture sees the self not as an individual, but in different kinds of relationship. Relationships can be so important that the self is submissive and may give in for the benefit of the family, the community and the country when the group interest is in conflict with the self-interest. Moreover, I consider that the hierarchical and patriarchal relationships from the origins of Chinese culture still exist today. Therefore, in understanding spirituality as being about the person or self, the self is always a whole within different sets of relationships in Chinese culture. The self as a person can never be separated from others in the family, society and in the world, from the past to the present, and particularly in Chinese culture.

Cultural influence is not only important in shaping the self in relationship, it can also aggravate the conflict between the Christian and healthcare influences because of the gender conflict in patriarchal Chinese culture. This can clearly be illustrated by MF's *Chiu Chau* example. In Chinese, especially *Chiu Chau* culture, male figures are the head and are in a dominating position, while women have submissive and lower positions. The father is the authoritative figure in the family and everyone, including the mother, has to obey his lead. This hierarchical *Chiu Chow* cultural influence, as mentioned before, has shaped the understanding of spirituality and the Level and Step Practice of MF. This cultural influence is subtle and has permeated over a long period of time. It is so natural to the person that the self may not even be aware of it.

In the third interview, I shared with MF the result of my data analysis. She reflected immediately that she had not realized that the impact of her *Chiu Chau* family culture was so great. She shared with me that her struggles in the practice suddenly began to make more sense. As mentioned before, she already felt caught between healthcare and Christian influences, manifested as a struggling self in the dilemma of practice. The gender conflict within her cultural self further amplified her struggles. As a pastor, MF

believes in and practices “continuing loving” care. However, influenced by her culture, she has difficulty in approaching and visiting male patients. She has a lot of “fear” when “getting close” to men with a *Chiu Chow* attitude. MF’s cultural influence of being a submissive female is in conflict with her pastoral role, in which she has to take the initiative. The cultural influence deepens the anxiety of her self, which is already confused about her pastoral role and spiritual healthcare staff role. I consider that her hierarchical Chinese culture aggravates the conflict between the Christian and healthcare influences and manifests as fear and struggle when she visits male patients.

At the end of the third interview, having realized the effect of cultural influence, MF shared with me that she was trying to accept her self and her “fear” towards male patients more. She also had greater appreciation for her “continuous love” in caregiving, instead of feeling sorry for her struggling self. She appreciated her efforts in initiating and continuing to care. Indeed, MF shared that by continuing to visit and show concern for a short while each time, there was breakthrough in the relationships with her male patients. Her patients showed a lot of appreciation when they were discharged.

Before we ended, MF updated me that she had moved back home to live with her husband. A lot of changes had occurred. Her husband was diagnosed with cancer a while after she moved back home. She wanted to take care of her husband and was considering leaving the chaplaincy service. She wanted to spend more time with her family. This is understandable. MF is a spiritual caregiver and relationship is an important theme in her understanding of spirituality. In these years of practice, she shared the same understanding with her patients, i.e., that relationship is what she has to uphold. Although MF had not yet fully decided at the moment, she shared that her *Chiu Chow* female role in the family was her pious consideration. In order to uphold the relationship with her husband she will most probably leave the service. In crises, the Chinese cultural influence again exemplifies its importance.

The impact of this cultural shaping influence was more than I originally expected. In understanding the needs of a caregiver, the family cultural background cannot be neglected. The Chinese cultural influence is important in shaping the understanding of spirituality as the self in relationships. It naturally shapes one’s past beliefs, affects the

present being, especially in crisis, and provides direction for growth in the future. The cultural influence also deepens the conflict between Christianity and the healthcare shaping influences. The dynamics between the different influences challenge the lives and identities of the caregivers and their practice.

7.44 Clinical Pastoral Training shaping influence

Before answering the third research question of how CPT might address the needs of a caregiver, we have to first take a look at the effect of the CPT influence in shaping the understanding of spirituality and its practice. In the text below, the number in brackets refers to the coding number in the relevant coding table.

There is variation among the three chaplains in their understanding of spirituality relating to God. They all consider that it is God who called and led them to CPT, however. In the training they all experienced and gained increased understanding of God through the clinical practice. Through clinical practice, they gained a better understanding of the nature of spiritual caregiving. Firstly, they all consider that spiritual caregiving is not human work, but is God's work, i.e., the Holy Spirit touches and participates in the caregiving (SY, 40, 42). God is in control, God prepares, God is present and works with the chaplain (MF, 16, 89, 97, 205; PW, 103). It is also God who makes the way, and God's guidance is in the process (PW, 102,113). Secondly, spiritual caregiving is about the co-operation between God and the caregiver, that is, there is a reminder from the Holy Spirit (SY, 50), the Holy Spirit or God works within the caregiver (SY, 52; MF, 90; PW, 111). God equips the caregiver and sometimes brings her to a specific ward (MF, 58, 160). God also heals within the wounded healer so that she can respond to His calling (PW, 110). I consider CPT an important influence in shaping the three chaplains' understanding of spirituality concerning God, through their clinical practice and their engagement in theological reflection/action.

During CPT, the three chaplains found their callings and identities. Their experiences of being called urged them to join the chaplaincy of caring. Their understanding of authentic identity and a healthy self was also important in sustaining them through difficulties. I consider CPT an important influence in shaping the self and identity. This confirmation of pastoral identity is significant in the conflict between healthcare influences and

Christianity, which causes confusion in the caregiver's identity as mentioned before. The confirmation of the pastoral role and an increased understanding of the self of the caregiver helps to solve the dilemma of practice.

All three chaplains have experienced different degrees of transformation in the self during CPT. This transformation includes firstly, a kind of self acceptance concerning the past. MF can face the problem and affirm that God is in the hurt (MF, 68, 63). SY has a better self-understanding and is willing to accept her own limitations (SY, 16, 26-29), while PW affirms that God has healed her. Secondly, there is a discovery about the self, that is, a new and wider perspective on the self. This includes some positive images of the self: "I have resources", "I am willing to open" (MF, 66,71); "I have difficulty yet I can", "I am strong", "enhanced my confidence" (SY, 7,8,10); "I have to be healthy" and "God works in me" (PW, 99, 111). Thirdly, there is a confirmation of the identity and call from God. The chaplains all had different reasons for joining CPT. However, all of them found their calling and an affirmation of their identity from God. Their identity not only transformed their self-image, but also enhanced their understanding about caregiving and gave meaning to their service. For example, PW affirms her pastoral identity in caring not only for patients but also for healthcare professionals (PW, 100, 106). MF is God's servant who cares with God's love (MF: 21, 186), while SY is an authentic self, walking together and connecting with God (SY, 48, 104).

Thus far, I have discussed CPT as important in shaping the understanding of spirituality in relation to God through clinical practice. It also shapes a positive image of the self and the authentic identity of the caregiver. This pastoral identity from God is able to strengthen and sustain the struggling self, who has been caught between the conflicts of the different influences. Below I argue that CPT is an important influence in shaping the chaplains' understanding of spirituality in connection to relationships.

CPT is purposely designed to take place in a small group with six to eight trainees in a group. Trainees practice and learn about caregiving by engaging in different kinds of relationships with group members, supervisors, patients and other healthcare professionals. In accordance with this design, the three chaplains all found that small group learning fosters a kind of openness and genuine relationships among the members.

Through the small group, they firstly have a better understanding about the person who is the self in relation to others and to God. Secondly, the different kinds of relationships enhance the growth of the self and facilitate confirmation of identity from God. (The importance of this was discussed above.) Thirdly, CPT is an important influence in shaping caregiving practice. The way the three chaplains' needs were addressed through the dynamic relationships in CPT led to a gradual formation of their values and attitudes in relation to caregiving.

The three chaplains consider that when they were in the training, they had needs for relationships, that is, to share and to connect. They also needed to be accompanied, supported and understood. Through the experiences in her relationships during CPT, SY gained increased understanding about the self who is always in relation to others and to God. Her self-understanding was enhanced and she considers that a whole and integrated self is the core of spirituality. Engaging in different relationships in CPT, she learned by doing reflection and integration. In her caregiving, she wants to keep company with patients so that they might see and find the self having meaning and hope. PW experienced a new relationship with God. Through group relationships, she experienced emotional release and felt relief. This healing within her was so important that she realized her pastoral responsibility is to "back up" the nurses emotionally. Her pastoral caregiving for patients has a psycho-spiritual focus. MF was cared for by her group members and supervisors. This kind of togetherness and non-hierarchical continuing loving care shaped her caregiving to become walking together with patients continuously. This non-hierarchical continuing love shaped by CPT, helps her to fight her fear, so that she can continue visiting male patients with a *Chiu Chow* attitude. CPT is thus an important influence in shaping the chaplains' understanding of spirituality. It also strengthens the self that is in conflict with the different influences. The relationship between the shaping influence of CPT and the chaplains' caregiving is illustrated in Table 7.4 below.

	CPT influence shaping the understanding of spirituality as relationship	Manifestation in practice
PW	Renewed relationship with God God heals, God works in me God's confirmation of pastoral identity	L role of chaplain L1: pastoring healthcare professional L2: emotionally "back up" nurses
SY	Enhanced understanding of relationship The self in relation to others and God A whole integrated self	F2 task of caregiving: F2a: see and find the self, find meaning in life F2b: "keep company" Empathetic understanding F2c: "inspiring hope using gospel"
MF	Love and togetherness group relationship "Crying together" Experience of caring and being cared Peer and supervisor love > God's love	Ea: value of Caregiving walk together Eb: attitude of Caregiving non-hierarchical continuing love

Table 7.4 CPT influence shaping the understanding of spirituality and the caregiving practice

Before joining CPT, each chaplain had her own needs or reasons for joining the training. Somehow, the needs which they may not have been aware of at the beginning had been addressed by the time they finished CPT. I consider that the helpful elements of CPT were instrumental in achieving this. More important, however, was the motivation and the willingness found in all three chaplains. PW was willing to "face her own pain", SY was courageous enough to "step out from her comfort zone", while MF was "willing to open" up and share about the abuse in her family.

Conclusion

For the three chaplains, the understanding of spirituality (*lingxing*) carries a definite set of meanings. It is deeply rooted in Christianity which is about God, about persons and about relationships. The shaping influences of Christianity, healthcare, Chinese culture and CPT have all played an important part in forming their understanding of spirituality and caregiving. However, the conflict between the different influences is great enough to challenge the selves and identities of the chaplains. These challenges have manifested themselves as difficulties, disintegration, identity confusion and dilemmas in daily practice.

Chapter 8

Narratives of Three Hong Kong Nurses

Introduction

The previous chapter explored the phenomenological world of three chaplains. This chapter aims at answering the research questions through the narratives of three registered general nurses. Each narrative is structured around the following six categories:

(1) Background information
(2) Understanding of spirituality
(3) Spiritual care practice model
(4) Clinical Pastoral Training experience
(5) Difficulties in practice
(6) Resolving the conflict

After the narratives, there is an overall discussion about the understanding of spirituality and the dynamics of the different influences affecting the group of Hong Kong Chinese Christian nurses. The information comes mainly from each person's reflections on joining Clinical Pastoral Training (CPT), transcriptions of the focus group interviews, transcriptions of individual interviews, and personal reflection notes written by the researcher during and after each interview. In the discussion text, direct quotes are put inside quotation marks and capital letters are used to number the categories.

8.1 The Phenomenological World of PC

Background information

PC is an experienced nurse working in the palliative care unit. She entered the profession in 1985 and has had more than thirty years of nursing experience. I did not know her before, but met her through one of her peers in CPT. She learned from her friend that I was doing research on spirituality and needed to interview a nurse with CPT experience. She agreed immediately.

PC took CPT at Queen Elizabeth Hospital from January 2013 to December 2013. She took the training in her own time after work. Not many nurses in Hong Kong take CPT to enhance their practice, because CPT is not accredited nursing training. PC shared with

me her reasons for taking CPT. Firstly, she did not understand what spiritual (*xinling*) care was. Secondly, she wanted to know how chaplains actually do spiritual (*xinling*) care. Thirdly, her boss told her that she had to work more with the chaplains. She should support the chaplaincy, and also offer *xinling* care in the hospital. In order to find out what she did not know, she took CPT. After the training, she continued to work as a nurse. At the time of the interview, PC was a nurse serving in the geriatric rehabilitation unit and the palliative care unit of the Haven of Hope Hospital, Hong Kong.

I interviewed PC twice and each interview was around one-and-a-half hours. There are 154 codes and 16 categories derived from the transcripts. The relationship between the categories is described in the following paragraph and illustrated in Figure 8.1 as follows.

PC needed to understand more about spiritual care. She took CPT to enhance her practice. She found that CPT was different from other nursing caregiving training. Having taken CPT, PC experienced personal growth and gained new perspectives on caregiving. This affected her role, and her values and beliefs concerning the practice of caregiving as a Christian nurse. For PC, nursing, caregiving, the healthcare system and Christian influences are in conflict and this conflict is manifested in her role as a Christian nurse. The jigsaw line illustrates the conflicting relationship between the two influences. In facing her limitations in caregiving, she relates well with the chaplain to provide continuous *xinling* care according to each patient's *xinling* need.

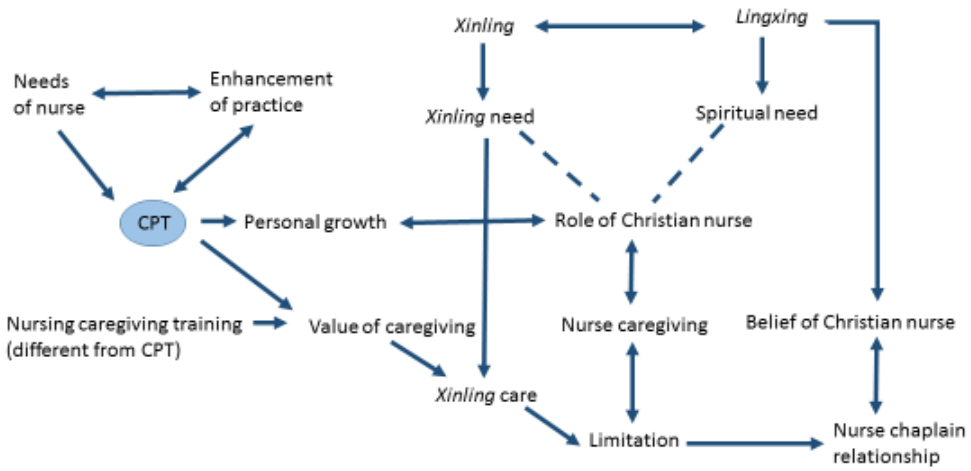

Figure 8.1 Relationship between the 16 categories derived from 154 codes

Understanding of spirituality

When I asked PC about the meaning of spirituality, she always used the term together with the word "care", i.e., *xinling* care, which she considered part of a nurse's caregiving. For PC, *xinling* care for a nurse is holism, with the physical being "part" of the holistic care. When spirituality is related to caregiving, whether it is *xinling* or *lingxing,* it is about the needs of a person. The two terms are therefore "similar" to her.

	Similar understanding of *xinling* and *lingxing* as relevance to needs		
Xinling	Individually different	about worries	beliefs
Lingxing	Individual yearning	feeling	perspectives about life beliefs

However, PC admitted frankly that there were differences in the usage of the two terms. The relationships of the terms to religion and faith were also confusing. For PC, faith is Christianity. The confusion is illustrated in the following table:

	Different word usage	In relation to religion	In relation to faith
Xinling	Used in hospital	related to different religion	may not be related to faith
Lingxing	Church	with religion	about faith

Spirituality for PC, whether it is *xinling* or *lingxing,* is related to religion in the healthcare context. However, she has a confused understanding about the relationship between spirituality and Christianity. On the one hand, *xinling* spirituality is related to various different religions. On the other hand, it may not be related to Christianity, which is also a kind of religion. There is also a difference in her understanding of *lingxing* spirituality in her Christian world and her healthcare world. For PC, *lingxing* is faith; it is the church in Christianity. Yet, in the healthcare setting, PC considers *lingxing* is "meditation", "cosmic natural therapy" and "Christianity and other beliefs". How does PC manage the differences? In the structural code, spiritual needs that are "individually different" are also about "interpersonal love" and connecting. Because "love is universal", love acts as a mediator in the gap between PC's healthcare world and her Christian world.

"Those who do not have faith still have spiritual needs. This is about the love between person and person. Even non-Christians would agree that love is most important in relationships. It is the dynamics of love that connect people together. This is not only limited to inter-personal relationship. This is also true for the relationship between God and human beings. This is just like the relationship between God and me" (I1S13-14).

Nursing caregiving practice

PC has been working as a nurse for more than thirty years. She is currently working with cancer patients in the palliative care unit. When PC shared her narrative, I could feel her energy for nursing as well as her passion as a Christian nurse.

PC became a Christian when she was in primary four. Although a lot of things have happened over the years, she is still an active member in her church. I would say that Christian faith is very important in her life and has shaped her practice of caregiving. This is reflected in her beliefs about being a Christian nurse, including: "a Christian nurse should care more", "should share God's love" and always hope that patients can "accept

the love with faith". Her Christian faith has shaped her identity as a facilitator, and her role and beliefs as a Christian nurse, although she "may not evangelize". These beliefs are represented in the structural code as follows:

B Beliefs of Christian nurse

B1 About the Self:
B1a "Doing more"
B1b "Sharing God's love"
B1c "Facilitate more God's love"

B2 About God:
B2a "Connecting God"
B2b "Showing God's love through our love"
B2c "God works through us"

B3 About Prayer:
B3a "Pray if patients want"
B3b "Pray means help"
B3c "Pray to hand over"

H Role of Christian nurse—Ha facilitator
Ha1 Facilitate by "love"
Ha2 Facilitate by "caring environment"
Ha3 Facilitate by "referring"

Christianity has shaped PC's beliefs and informed her role as a Christian nurse. From the structural code value of caregiving, we can see that as both a Christian and a healthcare professional, Christianity and the healthcare force have been in competition with each other. On the one hand, she has to address the needs of patients in a holistic way. On the other, she hopes that patients can receive the blessing of believing in God.

G PC's value in caregiving

Ga Healthcare value of caregiving
Ga1 "Holism"
Ga2 "Addressing needs"

Gb Christian value of caregiving

Gb1 “God’s mercy”
Gb2 “Blessing in believing God”

Gc Teamwork value of caregiving
Gc1 “Doing more” by “liaising more”
Gc2 “Liaising with” chaplain

The competition between Christianity and the healthcare influence might be reflected in PC’s values concerning caregiving. Yet, the competition has been resolved by her third value of caregiving, which is teamwork. PC considers teamwork very important. Teamwork with chaplains acts as a mediating force when Christian nurses like herself face the limitation of “lacking time”. She agreed a chaplain was a religious person and could be faith-focused. Chaplains had CPT or related training to address needs of patients and were able to connect with patients. When she co-operates well with chaplains, *xinling* care can be continuous.

PC provides holistic and deep *xinling* care to patients. She first comforts the patient naturally through good basic nursing care that involves physical and emotional care and deep *xinling*. As a facilitator, PC will then refer the patient to the chaplain, who will do the follow up for continuous care. However, instead of just “referring”, PC walks with the chaplain and introduces the patient to the chaplain. By “liaising with” chaplains as a team, patients can be continuously cared for. The structural code process of *xinling* care shows the way PC practices *xinling* care. Figure 8.2 is the diagram illustrating PC’s continuing liaison nursing care model.

Da *xinling* care process

Da1 Physical: “Decreasing the physical symptom”, addressing the physical limitation, “doing basic nursing care well”.

Da2 Emotion: “Explaining to address fear of unknown”, “comforting relatives” “settling down”.

Da3 Deeper care: “Comfortable enough to plan”, preparing for future, “sharing deeper if time allows”

Da4 Continuing care: “Walking together to introduce”, “liaising with”, “teamwork”

"It is easy to express care to the patients in nursing. For example, if they are uncomfortable, we can discuss with the doctor how to ease their symptoms. If they are in fear of the unknown, we can explain to them more clearly. If they cannot move well or have trouble with personal care, we can care for them with dignity. I think good nursing care is a kind of comfort to the patients and the relatives. This can decrease their *xinling* burden and worries. When they are more settled and comfortable, they may think about the future, the meaning of life and life after death. As a nurse, I think we are the right person to share with them. Patients are willing to listen. However, time does not always allow. As we are a team, it is good that the chaplains can visit during these moments" (I2S16).

Figure 8.2 Continuing liaison nursing caregiving model

Clinical Pastoral Training experience

Although PC is an experienced nurse, she is passionate to learn. Despite her rich experiences, she still found herself not knowing enough to provide spiritual care. This was her reason for joining CPT. She shared with me that in CPT she felt helpless and did not know what to do when patients shared their painful and suffering narratives. From the structural code change of CPT, I would say that before CPT, PC was in a vicious cycle of caring. As with most nurses, PC tended to use a problem-solving approach by doing more

caring. However, no matter how much she did in terms of *xinling* care, she still found herself helpless. After CPT, there was a change in her as a result of her increased understanding of the self, of relationships, and of *xinling* care. Through verbatim, clinical attachment for visitation, case debriefing, reading and reflection in CPT, PC benefited greatly. She made a comment that "Christian nurses should take CPT".

CPT experience and increased understanding

Aa Increased understanding of the self

Aa1: Different parts in me, "self-understanding"
Aa2: "Facing the hurt", "wider perspectives" seeing the past
Aa3: "I have need", I have the weakness

Ab Increased Understanding of Relationship

Ab1: "Inter-personally related", "profession" vs. "walk together"
Ab2: Not judging, "more understanding"
Ab3: "All are sinners", "others have and I have weakness"

Ac Increased Understanding in *xinling* care

Ac1: "Understanding deeper needs", communicating, comforting
Ac2: Genuine presence, "compassion", cared and caregiver are "equal"
Ac3: "Same pacing", meaning of walking together, accompanying
Ac4: "Not problem solving", care by listening, providing safety haven

PC experienced personal growth through an increased understanding of the self and of relationships. She had a new discovery about the self and reflected that people were interpersonally related. This brought her a new perspective on relationships and *xinling* care. Instead of judging others, PC considered that all people are sinners and she could be more understanding. Instead of being a professional who helped most of the time, she could have weaknesses. Instead of feeling "helpless" when seeing patients suffering and not knowing what to do, PC could help by listening. Instead of "leaving", not knowing how to help, and making referrals, she could "accompany" and stayed with the patients. Instead of problem solving, she could "hold more" (i.e., be comforting). There was a transformation within PC. The transformation and personal growth experienced by PC within CPT is illustrated as 8.3 in the following.

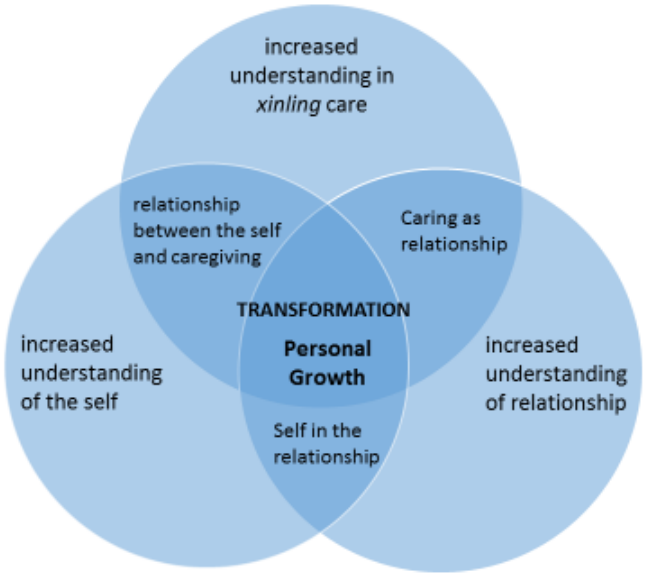

Figure 8.3 Transformation of the self in CPT

Difficulties in practice

During the interview, I asked PC what might enhance her caregiving. She shared with me her difficulties in practice. Hong Kong nurses, especially those working in the palliative care unit, are expected to provide spiritual care. PC agreed that there was "not enough" training for nurses. Taking herself as an example, she had to undergo CPT on her own time with her own effort. As PC remarked, nurses are aware that there are *xinling* needs to be cared for. *Xinling* needs include the meaning of life, life after death, fear, and the need for security. These topics were about "deep down feelings" and were "not easily touched". However, standard nursing caregiving training was a physio-psycho-social-spiritual approach and there was no "*xinling* care emphasis". Nurses might therefore find that they do not have enough know-how to practice.

The second difficulty in practice is that nurses as caregivers have to face life and death every day. There is a lot of fear in them and this can be reflected in the structural code needs of nurses. Nurses "dare not" talk about pain and suffering with patients. They are "fearful of asking" about patients' concerns, worries and have a "fear of not knowing how to respond" to life questions and frustrations. Nurses have their own needs as a person. However, they may not be aware of these needs and may not find them

acceptable as professional caregivers. PC therefore agreed that nurses would either "leave" the pain because of their helplessness or engage in problem solving that was not *xingling* care.

Thirdly, nurses might have their own religious beliefs. As a Christian nurse, religion has shaped PC's values and beliefs. Her *xinling* care is "naturally sharing about God" on the one hand and "holism" on the other. As mentioned before, there is conflict between her religious world and her healthcare world. Yet, nursing caregiving training in the healthcare context is more about "skill knowledge" and is not religious. The conflict within the healthcare professional as a person with different beliefs and values cannot be addressed in the nursing care training.

Nurses do not have enough training to practice spiritual care,. The standard training cannot address the needs of the caregiver as a person, who has struggles and conflict within.

Resolving the conflict

Thus far, we have seen how PC's Christian faith has shaped her beliefs and values in caregiving. Although there is a conflict between her Christian and healthcare worlds in terms of her understanding of spirituality and spiritual care, PC has the resources to resolve it. Firstly, PC loves learning. She joined CPT and experienced a change in her understanding of *xinling* spiritual care. She experienced transformation and personal growth. She gained new perspectives on the self and relationships, resulting in a different practice. She now liaises with chaplains to provide continuous good caregiving. She agreed that CPT had facilitated her caring.

Secondly, related training in caregiving is helpful in enhancing practice. PC considered that such training was about communication skills, listening and other relevant matters. Thirdly, the being of the caregiver, who is in the relationship within the team, is crucial for practice. PC emphasized the being of a caregiver was more important than training in caregiving. In the structural code, enhancement of practice, it is the "heart" and the "attitude" of the caregiver that counts. However, this self is not an individual self, but is constituted by her relationship within the team. I would say that caregiving in the hospital

is not an individual effort, but involves a team of different professionals. Teamwork is important in PC's practice. She liaises with chaplains to provide continuing *xinling* care. She also considers that joining colleagues' strengths together and serving as a team is important. In seeing herself in the team, she is willing to "walk an extra mile" and be a good caring model. She stressed the importance of practicing caring not only for patients but among colleagues in the team. I would say that the healthcare and Christian influences have shaped her teamwork emphasis and understanding of self.

Na Being of the caregiver

Na1: Heart, willing to understand deeper, "walking extra mile"
Na2: "Attitude", humble, "a whole person", appreciating

Nb Caregiver in the team

Nb1: Putting the strength together
Nb2: "Caring" for one another in the "team"
Nb3: "Good caring role model", "putting down oneself"

Nc Skill of the caregiver

Nc1 "Communicating skill"
Nc2 "Practicing listening"
Nc3 "Training"

As a Christian nurse, Christianity has shaped PC's beliefs and values in relation to spirituality and spiritual care. There was conflict between her healthcare and religious worlds, but love then became the mediator. CPT has also informed her role as a facilitator of God's love through liaising with different healthcare providers as a team. PC emphasizes the importance of the being of a caregiver. This being serves individually, but also serves with others together as a team.

8.2 The Phenomenological World of KM

Background information

KM is a young Christian nurse around thirty to forty years old. She has been working in the hospital since her graduation for fifteen years. At the time of the interview, she was

working in the Coronary Care Unit at the Prince of Wales Hospital, Hong Kong. I did not know KM at first. Her CPT group member introduced her to me. KM joined CPT in 2013 in order to learn more about spiritual care as she was interested in spirituality. Upon completion of CPT, she started studying part-time for the high diploma of Spiritual Formation and Spiritual Direction. When she knew that I was doing research about spirituality, she was more than willing to be my informant.

KM shared with me a lot of her life stories in nursing. She said that she could remember vividly the eyes and faces of different patients and their relatives when faced with life and death situations. She could see and feel their needs. Sometimes these needs were beyond physical care. However, as a nurse, she could tell that these needs were important and had to be addressed. Yet she did not know how to address them and found that her colleagues did not know either. As a Christian nurse, she "hoped to do some more". Therefore, she joined CPT so that she could "learn and serve better". She took the first unit of CPT part-time over a year. Upon completion, she did not continue because she found that she did not have enough of a foundation in theology to integrate the different areas of knowledge. However, she remained as a volunteer in the training hospital (where she did her CPT) to provide caregiving to home patients.

In the interview, KM shared with me that she had had some difficulties with her CPT supervisor. The supervisor confused her understanding of the self. As a CPT supervisor, I was sorry to hear that. She also felt that CPT has not brought many changes to her practice. However, she admitted that she experienced personal growth in that year, although she did not know the exact reasons. Moreover, she continued and enjoyed providing caregiving in the hospital as a nurse and visiting home patients as a volunteer. She also continued to learn about caregiving from other relevant training and services. At the time of the interviews, KM shared with me that she was taking a course in Christian spirituality and met with a spiritual director regularly.

I interviewed KM three times for the research. Each interview was more than an hour. She shared with me her different experiences and nursing stories. There are 212 codes and 16 categories derived from the first two interviews. For coding details please refer to

the table in the appendix. The relationship between the categories in KM's narrative are summarized in the following paragraph and illustrated in figure 8.4 below.

KM's understanding of spirituality was expressed as *lingxing* and *xinling* in Chinese. Each term was related to different things. *Lingxing* was related to religion and the relationship with God. *Xinling* was related to chaplaincy care and Clinical Pastoral Training. As a nurse, KM was passionate about responding to the needs of patients. However, she felt frustration as a Christian nurse and there were difficulties in practice. These are illustrated as red rectangles in the diagram. There are some other factors that might have affected her caregiving. CPT is one of them. KM gained her understanding of CPT from some chaplaincy magazines and stories. She thought CPT was a kind of spiritual care training that would be helpful in addressing her needs and she therefore joined the training and had some new experiences. Christianity is an important influence for KM, although the varied understandings of spirituality among Christians and the difference between the way non-Christians and Christians practice in the healthcare context makes her frustrated. She shared with me that she tries to keep smiling in order to show her concern to patients. The spirituality of the caregiver was also important. The smiling face in the diagram shows KM's commitment as a Christian nurse trying her very best in caregiving.

Figure 8.4 Relationship between the 17 categories derived from 212 codes

Understanding of spirituality

For KM, there are two terms, *lingxing* and *xinling*, making up the Chinese expression of spirituality. Each term connotes different meanings, yet both terms have a confused relationship with religion and Christianity. The relationships between them are also confusing.

KM was well prepared for the interview. She knew beforehand that my research was about spirituality. She had prepared a note about the meaning of *lingxing* spirituality. She told me that she came up with the understandings after some reading and reflection. KM reflected that firstly, there were differences within Christianity concerning understandings of *lingxing*. She said that, for most people, *lingxing* in Christianity was about "prayer, bible, Church going". It was more about the "behavioral". Yet for KM *lingxing* meant being "united with God", "selfless", a "beneficiary to others" and concerned the "origin". Despite these differences, KM considered that *lingxing* was commonly accepted as "relationship with God". However, she said that within Christianity, people were "not clear" when they talked about relationship with God. Her understanding of relationship with God might be different from that of other Christians. She described it as a personal "experience". Relationship with God could not be separated from the relationship with self, with others and with the world. Relationship with God was all these "relationships in relation to God". KM accepted that there were different views on this relationship, and she agreed that it was "complicated".

Secondly, KM considered that the relationship between *lingxing* and religion was confusing. She categorized the relationship into three types. Firstly, *lingxing* connotes the meaning of a relationship with God. This is the same as the understanding of *lingxing* in Christianity. Secondly, *lingxing* and religion are closely related, being different and similar at the same time. They are the same in the sense that both are about rational thinking. *Lingxing* is about beliefs and also about life. For Chinese, it relates to "*shangtian tiandi*" (i.e., heaven and earth). Similarly, religion is about rules. Yet, compared to *lingxing,* religion is "narrower" because it is related to "organization". *Lingxing* is thus a broader term. Finally, for KM, "*lingxing* and religion are different". She emphasized the differences between them. *Lingxing* is about life, while religion is an

institution. *Lingxing* is not something "from others", but is a personal experience, while religion is formal and within an organization. She admitted that the understandings of *lingxing* in relation to religion could be so varied that they were "individually different".

As mentioned above, KM considered that there are differences in the understanding of *lingxing* within Christianity. The relationship between *lingxing* and religion is also confusing, as illustrated below in table 8.1:

	Lingxing and religion the same	*Lingxing* and religion related	*Lingxing* and religion different
Lingxing	Relationship with God in Christianity	broader term Not necessarily with religion beliefs	life "not from others' input"
Religion		"limited" than *lingxing* rule	organization formal

Table 8.1 Three types of relationship between *lingxing* and religion

As for the other term of spirituality, *xinling*, KM considered that it was "used together with care" (i.e. *xinling* care). It was a "chaplaincy" term related to "love" and it was about "accompanying". Yet, she admitted that she "does not know", as most people "do not understand deeply enough" about *xinling* care. She also said that there were differences in the understandings within Christianity. In her experiences in CPT, *xinling* care was often taught as "case" studies and "did not relate to Jesus as example".

Apart from the confusion surrounding the two different expressions of spirituality in Chinese, *xinling* and *lingxing*, and their respective relationships with religion, KM also questioned whether the differences between *xinling* and *lingxing* were actually significant. In the structural code *xinling lingxing* relationship, there were three reasons given. Firstly, she considered that the understandings of both "terms are individually different". There were also differences in the usage of the terms. "The usages of the same term can be varied even with the same person". Therefore, KM tended to think that *xinling* and

lingxing were the "same but used differently". Secondly, she remarked that there were "different understandings within Christianity" and it was "incoherent". Some consider "*linxing* is more high-sounding". But KM attributed this to the discrepancy between theory and practice. Thirdly, KM considered that the differences and the similarities between *xinling* and *lingxing* were "difficult to distinguish in details".

As seen above, the understandings of spirituality, whether it is *lingxing* or *xinling* are confusing for KM. Their relationship with religion and Christianity cause even more confusion. To conclude, KM considered that spirituality is used in strange ways nowadays. Their understandings "varied strangely" both within Christianity and in the healthcare context.

Nursing caregiving practice

KM understands *lingxing* as being about relationships and she therefore likes smiling when caring for patients. When KM shared with me her caregiving stories, I really appreciated her caring heart as a young nurse. KM also shared with me the reasons for her caring heart. There was a time in life when she had some difficulties and went to see a counsellor. That counsellor listened to her attentively and caringly and she learned to do the same. In her course about Christian spirituality that she was taking at that time, her spiritual director showed a lot of care for her, and she was therefore learning what good caring was. There was also a time when she made a mistake in cleaning the wounds of a patient, yet the patient accepted her and did not judge her, and in turn she also learnt to become more accepting of others. As she was blessed by God, she would like to give blessings in return. She said that if she could understand and connect with herself, she would be able to connect with others. KM's beliefs, values and attitudes guide her caregiving. They are represented in the structural code as follows:

G Spiritual nursing caregiving

Ga Belief:

Ga1: Cared > caring
Ga2: Listened > listening
Ga3: Accepted > accepting
Ga4: Blessed > blessing

Gb Value:

Gb1: Connection
Gb2: Addressing needs

GC Attitude

Gc1: Natural as friend
Gc2: Humanistic

KM shared with me several stories that had touched her very much. She "did not do much", but patients showed her a lot of appreciation. In critical moments, she connected with patients by showing her understanding. She would care for their cares, accept their responses and accompany them. Even on regular days, she liked smiling and going to patients' bedsides and talking with them. As she considered *lingxing* was about "instinct", and "human nature", her connection with patients was from "person to person" and they were as "natural as friends". It was a process experienced together by both the cared-for and the caregiver. Instead of "highlighting" and emphasizing spiritual care, KM considered nursing spiritual caregiving to be physio-psycho-social-spiritual and simply natural. In the structural code, the spiritual care element includes "giving water to drink".

KM is a Christian. She admitted that her Christian faith has affected her beliefs about life and death. Because of her faith, she considered that connecting the world and God was important in life. She therefore considered herself to be providing spiritual care if she could connect the patients with transcendence, "sing gospel songs" together with Christian patients, share with patients God's love and the "meaning of life", and "pray for" their needs. However, KM reflected that it was not easy to include the above spiritual care elements into caregiving. Compared with chaplains, nurses as spiritual care providers can "more easily approach" patients. Yet, patients do not easily identify her as a Christian or connect her care with God. She has to make the "link" by prayer or by saying "Jesus loves you" to the patients. Although KM was not sure and "didn't know" whether this was the correct approach, she tells herself that there is "no need to link with God immediately" in caring. All one has to do is "try my best to respond" and care naturally. I consider that KM's caregiving is natural nursing caregiving, starting with smiling and bedside talks with patients. The caring model is illustrated as Figure 8.5

Figure 8.5 Natural nursing caregiving model

Difficulties in practice

KM wanted to carry out her nursing spiritual care naturally, yet she encountered some difficulties in practice. Firstly, confusion about spirituality in the healthcare context caused frustration in her. Although nurses are supposed to provide spiritual nursing care, KM found that "nurses don't understand" it. Spiritual care in the healthcare context was "very difficult and [too] mystical to be described". Communication was "very difficult" because "different people have different understandings". KM was confused about whether talking was "psychological care" or "psychosocial care" or it "may be spiritual care". Her understanding of the concepts was so confused that KM found it "troubling". It was "clearer to say holistic care than spiritual care".

Secondly, she was confused about the healthcare service itself. KM found that although everyone was talking about spiritual care in the service, "not many people really showed concern". Assessment of spirituality was generally only about determining the religious faith of patients. Since spiritual nursing care is about addressing the needs of patients, spiritual care nowadays is often just left as "drawing curtains" and "providing privacy". There is a gap between understanding the importance of spirituality and the actual

practice of spiritual care. According to KM, nurses sometimes claim that they are too "busy" to carry out spiritual care, but in reality, "not many nurses facilitate" spiritual caring resources. KM worked in a coronary cardiac unit (CCU) where she found there was a better ratio of nurses to patients. Yet she admitted that sometimes there would be "too many duties to care" for patients. This brought difficulties in the practice of a good standard of nursing care, not to mention spiritual care.

Thirdly, there was confusion about Christianity. KM's beliefs and values towards nursing have been shaped by her Christian faith. However, she found that "church teaching does not help" her in practice. Among Christians, there were also differences in practice depending on their understanding of *xinling* care. Some might just do their jobs, but not really care about the patients' cares. They might fulfill their responsibilities, but not think about how to care better. There were also differences in Church teachings about love, in explaining what was right and what it means to be a good Christian. These variations caused confusion in KM.

Fourthly, as a Christian and as a healthcare professional, there was conflict between KM's Christian world and her healthcare world. KM agreed that in nursing spiritual caregiving, "no one cares unless one really wants to". She was the one who wanted to and believed that "there is something I can do to help more". However, in the structural code frustration of Christian nurse, there are difficulties such as church culture vs. hospital culture, gospel vs. patients' needs, and the fact that sharing about God is not nursing. KM found that as a nurse, talking about God could lead to "complaints" by patients. She also found that the gospel might not be able to address patients' needs because the church and hospital cultures are different. There was thus a discrepancy between her two worlds.

Fifthly, KM also had her own personal difficulties. The structural code affecting factors of spiritual nursing care is represented as follows:

M Affecting factors of spiritual nursing care

Ma: Time and space
Mb: Relationship with God, others and world
Mc: State of being
Md: "No peace" > no "space to aware"

KM said that she was affected by different kinds of relationships, including those with God, others and the world. The emotions aroused by these relationships affected her state of being and could decrease her awareness of the needs of patients. Relationships thus affected her practice of spiritual care.

Clinical Pastoral Training experience

KM wanted to know more about *xinling* care, and therefore she joined CPT. However, she shared with me frankly that her experience in CPT was not what she had expected. She had some difficulties with the supervisor. She also faced a dilemma in her group which was made up of some pastors and lay Christians. She said that the group members nevertheless "widened her perspectives". In her CPT group experience, the dilemmas are expressed in the following.

O CPT Group experience

Oa: "Same faith" vs. varieties
Ob: Faith vs. life
Oc: "Miracle" vs. reality
Od: Theory vs. practice

KM found that even among Christians of the same faith, there were many differences. In her experience, pastors presented their lives as miraculous, but at the same time their faith did not match the reality. There was a discrepancy between their Christian lives in theory and in practice. However, through "relating" with different people in the training, KM admitted that she could still "learn from others". Her perspectives were also widened. She gained better understandings about church reality, about "Christian elders" and the limitations of religious persons.

KM experienced some difficulties with her supervisor. She had a confused understanding about the self while trying to figure out whether it was her problem or the supervisor's problem. She reflected that the personal dynamics were "complicated". Yet, I would say that through the difficulties, KM demonstrated personal growth in the form of increased self-understanding. She learned that she had the choice to listen to criticisms or not, and that she was able to differentiate the self from others.

KM found that the reading requirement in CPT was helpful. The visitation experiences enabled her to understand God more. Through the home visits in pairs, she could "experience the Holy Spirit" together with the cared-for and her partner. This experience was so true to her that she continued the home visits as a volunteer with the chaplaincy after her CPT study.

Resolving the conflict

KM found herself wanting to help, yet "did not know how". As a Christian nurse, she was sure that "there was something" she could do to "help more". She was passionate about bringing faith, hope and love to patients through her caregiving. With this passion for more, she joined CPT. Although CPT failed her expectations and she had difficulties in the practice as mentioned above, she continued her caregiving. At the time of the interviews, she was still working as a nurse in the hospital. She made home visits as a volunteer for the chaplaincy office. She was enriching herself more by studying for the high diploma in spiritual formation and spiritual direction.

When I asked KM about the factors that sustained her caregiving, she remembered the time when she did not have any training or many experiences in caregiving. She found that she just cared and built "natural" relationship with patients, accepting and being accepted by them. This kind of life connection touched her and sustained her continuous caregiving. I still remember KM's shining face when she described her relationship with a young female patient. The chronic SLE patient would eat late night snacks together with her and her colleagues. The patient knew the nurses and gave them special and lovely names according to their characteristics and interests. She reflected that this might not be "formally" accepted as spiritual care, yet, it was "humanistic" and both the cared-for and the caregiver were touched.

As mentioned above, KM continued to serve as a volunteer for the same hospital chaplaincy after CPT. I wondered what made her stay on in the volunteer service. I found that her experiences in the home visits were special to her. She could feel the "touch of the Holy Spirit". This experience of touch was also the experience of her partner and the cared-for. This real and true experience told her that she was not alone in the caregiving, but that God was also present.

When facing difficulties in spiritual nursing care, KM found that it was important to connect with the self, i.e., the spirituality of the caregiver. In the structural code, spirituality of a caregiver is expressed as follows:

I Spirituality of a caregiver

Ia The self with God

Ia1: Connecting self with God
Ia2: Connecting self in the world with God
Ia3: Connecting Bible and reality

Ib The self and needs

Ib1: Needs to be nurtured
Ib2: Needs to aware
Ib3: "Non-stop seeking"

There are many challenges in caregiving as a Christian nurse. For KM, the passion of the nurse to serve and connect naturally with patients is important. The real experience of God and the spirituality of the caregiver are also valuable resources when facing frustration as a nurse.

KM has a confused understanding of spirituality. Her understanding is complicated by the confused relationship between spirituality and Christianity. KM finds that there are difficulties in providing spiritual care as a Christian nurse, because there is conflict about the understanding of spirituality within the healthcare service, within Christianity itself and between her healthcare and Christian worlds. However, the passion to practice spiritual nursing care, the touch of God in the process of caregiving, and the spirituality of the caregiver are some of the resources that KM has to draw on when facing the difficulties in practice.

8.3 The Phenomenological World of SC

Background information

SC is a nurse who is single and around fifty years old. She served in the hospital for eighteen years before leaving the service in 2008. The hospital she served at was

established by a Christian missionary. Since then it has been subsumed under the management of the Hospital Authority, Hong Kong. When SC resigned, she described herself as “lost”. She needed to stop and take a rest. She shared with me that there was a lot of pressure at work. There was also no “space” for her to provide the kind of care that she wanted to give. She hoped that the break could help her seek a new direction in life. She wanted to find a way to serve God in the next chapter of her life. She therefore decided to study for a diploma in theology as well as other related courses. SC shared with me that she worked as a nurse again one year after leaving the hospital, and was therefore working and studying at the same time. After finishing her studies, she joined CPT. There were three main reasons she took the training. Firstly, CPT could enhance her personal growth. Secondly, she wanted to learn how to do caring better, including learning how to listen and respond to patients. Thirdly, she wanted to know how to share the gospel in caring, so that people would be able to get to know Jesus.

SC had her first CPT unit in 2013-2014 and she continued the training for two more years. At the time of the interviews, she was in her third unit of CPT and was also working part-time as a nurse in a convalescence home. She found that being a part-time nurse was good. It offered her time flexibility and financial freedom for continuous learning. I got to know SC through the introduction of chaplain SY. SC was a volunteer of the chaplaincy at Prince of Wales Hospital where SY served. When SC heard that I wanted to interview a nurse who had CPT experience, she was willing to be my informant. She even introduced to me to two of her CPT group members who were also nurses. I have to say that without SC’s enthusiasm and active assistance, this research might not have been able to proceed.

I interviewed SC twice for the research. Each interview was more than one-and-a-half hours in length. A trusting relationship was quickly established. She was eager to share with me her ups and downs, even though they might not have been relevant to the context. There are 206 codes and 20 categories derived from these interviews. For coding details, please refer to the table in the Index. The relationships between the categories in SC narratives are summarized and presented in figure 8.6 as follows.

SC is a committed Christian nurse. Her belief shapes her identity, calling and intention in caregiving. Her nursing care and *xinling* care is that of a Christian nurse. SC shared with me that she left behind nursing caregiving at the hospital after eighteen years of service. This was more or less related to the pressure of being a nurse, and the struggle of being a Christian nurse who has been hurt and has experienced difficulty in nursing practice. These issues are represented as red rectangles in the diagram. There was frustration inside SC and there was confusion over whether spiritual care was *xinling* or *lingxing* care. Some years later, with some understanding of CPT and hoping that this course might be able to address her needs, she joined the training. During the experience, she provided *xinling* care as a chaplain intern. She found it useful and developed a better understanding of *xinling* care through chaplaincy care.

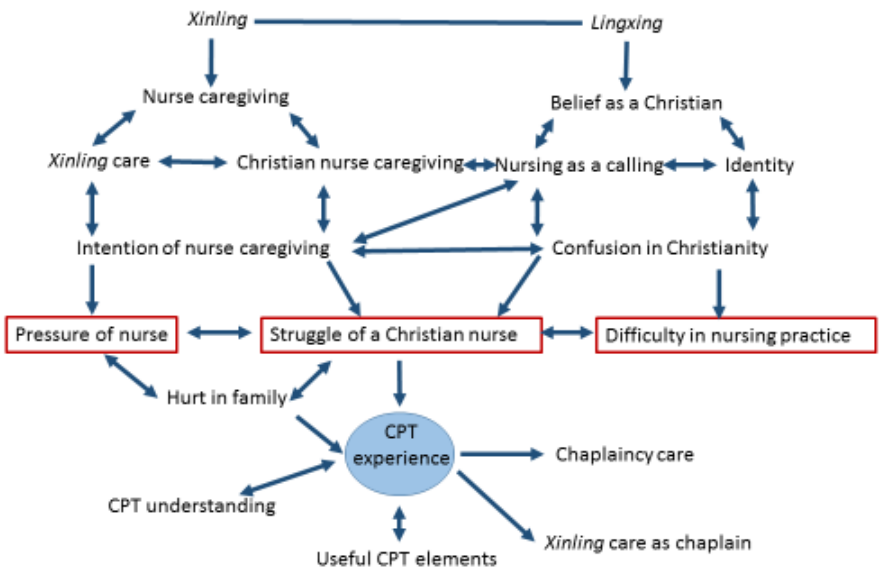

Figure 8.6 Relationship between the 19 categories derived from 206 codes

The understanding of spirituality

At first, SC said that "*xinling* and *lingxing* are the same". She considered there were two different expressions in Chinese because spirituality was "difficult to translate". Spirituality, whether *xinling* or *lingxing*, was "spirit-related". It was something that "everybody has", was "deep in the heart" and therefore, was "hard to be touched". It was "emotionally related", it was about thought and was "difficult to express". However, SC found that *lingxing* connoted a further and deeper meaning than *xinling*. Therefore, it was "harder to care more deeply" especially if patients did not have any "religious faith". *Lingxing* was thus related to religious faith and *lingxing* care was "based on deeper relationships". *Xinling,* on the other hand, might lead to "religious faith". In this way, *lingxing* and *xinling* are different, because each has a different relationship with religious faith. SC had a certain confusion in her understanding of spirituality. Sometimes *lingxing* and *xinling* were the same to her, while at other times they were different, especially in relation to religious faith. SC's understanding of spirituality was often expressed as "may or may not be", "probably" and "not sure". Her understanding of spirituality is shown as follows:

	Same	Different	Confusion
Lingxing	"Deep in the heart" "Difficult to express" "Hard to be touched" "Emotional related"	related to the creator seeking the creator "further a bit, deeper" "connecting further"	"may or may not be" Not sure
Xinling	Thought "Everybody has" "Spirit related"	"leading to religious beliefs"	"probably difficult to be understood"

Nursing caregiving practice

When SC was a young girl, she wanted to be a nurse when she grew up. Although she only joined the profession after several years in other jobs, she found it amazing how God had prepared her through those jobs. Understanding SC's caregiving practice cannot be separated from her calling from God to be a nurse.

From the structural code, nursing as a calling, there was firstly the experience SC had when she first joined the profession. When she saw the hospital, she was “moved”. She felt that nursing was “God’s preparation” for her. Everything that was prepared was “amazing”. Secondly, during training, she was cared for by some Christian nurses. This inspired her to become a mentor when she graduated and provide caring for her colleagues. She said that she experienced “growth” in God through caring. In this way, caregiving for SC was “simple and natural”. Her experience informed her that it was God leading her into the caring profession. She felt thankful and was “willing” to be a Christian and provide caregiving.

SC’s Experience of nursing as a calling is represented in the structural code as follows:

God’s preparation > being cared > caring > growth > willingness

Joining the nursing profession was God’s preparation and God’s calling for her. From this amazing experience, I would say that SC’s identity and beliefs as a nurse were shaped by her Christian faith.

Identity: I am “a Christian”, “God’s channel”, “Jesus’ representative”

Belief: “God’s presence”, “sees Jesus through me”, “reconciliation”

While SC is the representative and channel of God, she is also a healthcare professional who meets people from different walks of life with different beliefs. I am of the opinion that the healthcare influence has shaped her values and attitudes in caregiving.

As a Christian and as a professional nurse, SC has a dualistic role. Christianity has shaped her identity and beliefs, while the healthcare influence has shaped her values. SC’s caregiving comes from a juxtaposition of Christianity and the healthcare influence as shown in figure 8.7. On the one side, SC is a nurse tending to patients’ physical needs, including medication, physical massages and emotional care, including listening to worries and letting patients express their concerns. SC is a nurse who considers family relationships important and she therefore also comforts relatives, preparing them to say goodbye so that there will be no “regret” on either side. She also makes referrals if needed.

Juxtaposed against the healthcare influence is Christianity. SC has the hope of "patients getting to know God". Therefore, she evangelizes, sings with patients and prays. She reflected that her *xinling* care was about "the relationship of God and me". She does not only pray for and with patients, she also prays to God that she might "care according to the needs" of patients. She also found that both the caregiver and the cared-for were "moved" in the caregiving. I could feel that SC loves her patients, is sensitive to their needs and responds always. She said that it was God working through her caring. I have therefore used a heart shape to represent her emotion of being "moved" in nursing and in seeking God. SC's nursing spiritual caregiving model is illustrated as Figure 8.7.

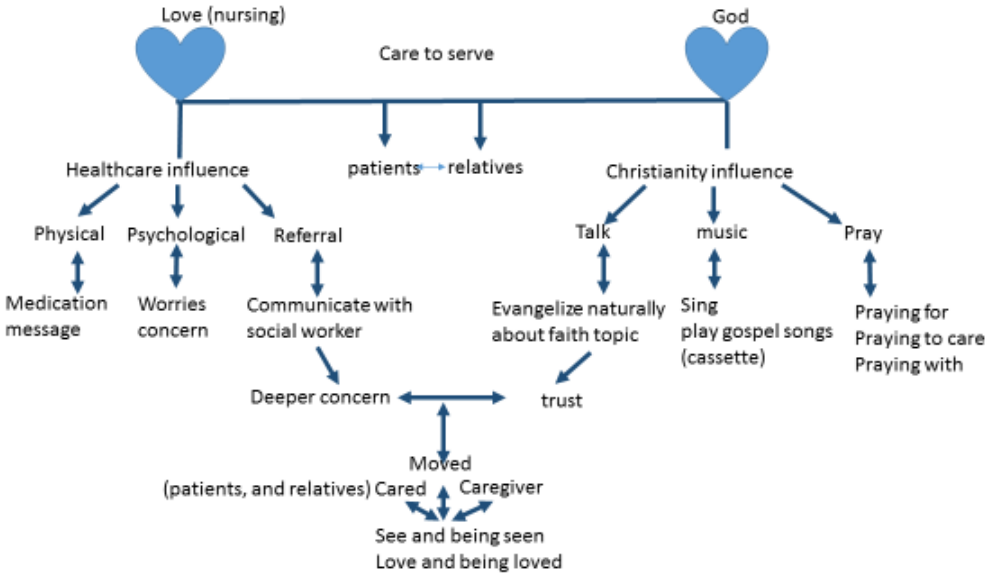

Figure 8.7 Juxtaposition nursing/spiritual caregiving model

Difficulties in practice

As mentioned above, SC left hospital nursing after eighteen years of service. Difficulties in practice manifested themselves and became some of the reasons for SC leaving nursing, despite it being a calling and amazing.

Firstly, there was "no space" in the hospital milieu for SC to provide her Christian nurse caregiving. It was too busy in the ward for her to carry out "proper" nursing care. She found she was not free to practice how she wanted. There was also a demand and

expectation on her as an experienced nurse to take on a supervisory role, for which she was not ready, as she found herself as yet insufficiently capable.

Secondly, there was a conflict between her nursing work and her Christian nurse caregiving. There was thus a conflict between her healthcare and Christian worlds. As mentioned above, Christian faith was very important for SC. It had shaped her identity and beliefs in caregiving. There was also an intention in SC that patients would come to know God. She would therefore evangelize to the patients in her training hospital, which was originally a Christian hospital. However, she knew that this "may not be allowed" in the standard healthcare milieu. Some of her colleagues in the convalescent home "had reminded" her not to do this. Her identity was being challenged and she felt "lost".

Thirdly, there was conflict in her inter-personal relationships at her work place. There was malpractice among her colleagues, but she found she did not know how to "express" her feelings. Because of the "fear" of disharmony, even when she had "anger", she found it difficult to comment. She was not clear anymore about whether she "was the problem" or if there was a problem.

Fourthly, there was pressure and struggle within her as a Christian nurse. For example, she sought God's will when she planned her future, but there were also the needs of her family to consider. Later, after she had completed CPT, she was considering serving as a chaplain and left the part-time nursing job, but then had to face the fact that a full-time chaplain receives a lower salary than a part time nurse. Serving God versus daily need in life caused conflict within her from time to time. SC frankly admitted that, in "seeking God's will", she was "troubled". It was too "complicated" to understand. I consider that this difficulty was due to the confusion in Christianity. SC agreed that there were "different perspectives", different kinds of Christians and there was also conflict in church. All these issues are "complicated".

Fifthly, apart from being a Christian and a professional, SC is also a family member and family is very important to her. Yet she shared with me that in her family's cultural background, she had "no say". She was not allowed to "express" herself in order to avoid conflict. She found that she had the tendency to withdraw hurt. In her relationship with her family, she felt "strange" and could not "understand" the inter-relationships. There

was a “wall” between family members. She would like to “open” up, yet communication seemed impossible. Family relationships and the needs of the family sometimes became a source of stress for her.

There was frustration in SC, which she described as being “lost”. There was conflict in her Christian world. There was also conflict in her dualistic role as a Christian and a nurse. The healthcare and Christian influences which shaped her values and beliefs were sometimes in conflict. Her Chinese family shaped her reaction to conflict. She finally had to stop and take a break from her nursing-caregiving.

Clinical Pastoral Training experience

SC was “lost” in her identity and calling. She expected CPT to help her deal with problems in her personal growth. She also wanted to learn how to share the gospel fully, so that she could help the “patient to know Jesus”. In the category of CPT experience, there are sub categories which reflect SC’s experiences.

H1 CPT experience and personal growth

H1a More perspectives of self
H1b Facing the hurt in growth
H1c “I can open and share”

H2 CPT experience and relationship

H2a Increased understanding the family relationship
H2b Being able to “express myself”
H2c “Breakthrough” relationship

H3 CPT experience and caregiving

H3a Caregiving is “not”: “not evangelize”, “not necessarily to talk”
H3b Caregiving is “just”: “just care the cares”, “just listen to understand”
H3c Caregiving when about faith: [patient] raise religious topics > [discuss] religious faith in relation to meaning and to life

During CPT, SC provided *xinling* care in the form of chaplaincy care. She gained a new understanding of *xinling* care, i.e., that it was about the “not”(s) and the “just”(s). When she could “accompany” and be “present as a whole person”, patients would “raise”

religious topics themselves. She could then gain a deeper understanding of patients' religious faith, and discuss their religious faith with them in relation to their daily lives and the meaning of life.

SC found that clinical visits to patients and the discussions in the group were useful in CPT. She stated that "everyone has a blind spot", but through trusting the group, "reflecting", and through the different perspectives of the members, she experienced personal growth. There was a change in her understanding of self, of caregiving and a "breakthrough" in family relationship became possible. I would say that these three changes were interrelated. She was lost before joining CPT and there was a breakthrough in her life as a result of CPT.

Resolving the conflict

Thus far, it is clear that there were difficulties in SC's caregiving as a Christian nurse. There was conflict in each of her worlds and between the different worlds. When she felt "lost" in her identity and calling, she joined CPT. I consider that SC's willingness to seek and to understand more fully were crucial for her breakthrough experiences in CPT.

When I listened carefully to SC's narrative, I could tell she has been seeking all through her life. There have been struggles in her spiritual journey. She started her seeking when she entered nursing. She shared with me that at that time, she not only wanted to understand nursing, but she also wanted to "understand God more through nursing". She considered caregiving as a Christian nurse as being "about the relationship of God and me". Therefore, she would pray to understand more and serve patients accordingly. Seeking to understand more is again one of the reasons she joined CPT. In CPT, she admitted that she could "understand God more". The seeking has not stopped, however. At the time of the interview, she was still struggling with understanding and did not know whether she should serve God as a chaplain or as a nurse.

SC was eager to understand God more, to seek her identity, and find a suitable way to serve God. I reflected that although SC left hospital nursing some years ago, she has not given up her caregiving. Despite all her struggles, she has continued her service at a nursing home as a part-time nurse. She has served as a volunteer in the chaplaincy office.

She has also joined different training programmes and has been preparing herself through continuing education. I consider that her calling is her strength. She has a clear identity as a "Christian" caregiver who is "Jesus' representative". Her experience in *xinling* care also sustained her caregiving in her roles both as nurse and chaplain. In *xinling* care, her experience can be described with the following codes.

Ia *Xinling* care experience of caregiving:

Ia1: "God's participation"
Ia2: "Holy Spirit is in control"

Ib *Xinling* care experience of relationship

Ib1: "Holy Spirit is leading me"
Ib2: "Holy Spirit inside me"

Ic *Xinling* care experience of feeling

Ic1: "Satisfied"
Ic2: "Moved"
Ic3: "Being recognized"
Ic4: Compassion

SC was confused about spirituality. This was not only because of the conflict within each of the shaping influences of Christianity, the healthcare system and her Chinese culture. There was also conflict between these different shaping influences. CPT has addressed some of her needs, which in turn has brought a breakthrough in her life. Though SC is still struggling along her spiritual journey, she experiences the Holy Spirit with her and in her caregiving. This becomes a strength for her to keep seeking and responding to the loving calling of God.

8.4 General Discussion of the Three Nurses

Having looked at the narrative of each nurse, the following paragraphs present a general discussion of the three nurses' understanding of spirituality and the kinds of influences that might have shaped their understanding and practice.

8.41 Understanding of *lingxing* spirituality among the nurses

All three nurses agree that there are differences in the usages of the two terms for spirituality expressed in Chinese, yet also state that the two terms are similar. They share the same understanding that spirituality is related to caregiving and is rooted in Christianity. When spirituality is related to caregiving, *xinling* is often used in conjunction with it to become *xinling* care. *Lingxing* spirituality is often associated with Christianity. It is from the church and is about God. Therefore, both *xinling* and *linxing* carry a definite set of meanings in relation to spirituality. Together, the two terms convey a complete understanding of spirituality, which is about the person, God, and love.

Firstly, the nurses consider that *xinling* spirituality is about care for a person's needs. This includes caring for the emotions and feelings of the person, such as their worries and concerns. It is also about rational thinking, perspectives and beliefs about life. The human need for God is important and has to be considered also. For the three nurses, *xinling* spirituality is not easy and is difficult to get hold of. Therefore, *xinling* care requires a kind of accompanying and listening so as to provide comfort. In addressing the individual needs of patients, the three nurses emphasize holism. Physio-psycho-social care and "drawing curtains" are regarded as different forms of *xinling* spiritual care. Despite the vagueness of the term spirituality, the understanding of *xinling* spirituality in relation to caregiving is similar among all three of them.

Secondly, *lingxing* spirituality is rooted in Christianity. All three consider that *lingxing* spirituality is from the church and is about faith. It is also about the relationship with God, i.e., seeking and connecting with the creator. KM further elaborated that the relationship with God is related to the relationship with the self, with others, and with the world.

Thirdly, spirituality is love. Love is an important theme for the three nurses. Love is associated with all of their *xinling* care in the form of their beliefs and roles as Christian nurses, and their attitude of caregiving in response to the needs of patients. Love connects the spirituality, *xinling,* of the person, and the *lingxing* of God and love is the universal need of human beings. As Christians, they have all experienced God's love. They can then care with love, so that patients can also have the feeling of being loved; and can accept the love between persons, love in the family, and hopefully also the love of God

with faith. In this way, love is about the different kinds of relationships between persons, and between God and persons.

The three nurses' understanding of *xinling* spirituality, is related to caring for the needs of a person. *Lingxing* spirituality is used often in relation to Christianity, which is about God. The two terms together connote the complete understanding of spirituality. However, *lingxing* spirituality has varied meanings in the nurses' phenomenological worlds compared to *lingxing* spirituality in the context of their Christian worlds, which mainly is about God. In the healthcare context where they work every day, *lingxing* spirituality is thus not only about Christianity, but also includes other beliefs. It can be meditation or a kind of therapy and it "may or may not be" religious. *Lingxing* spirituality is about the "meaning of life" and "transcendence". It can also be something natural in daily life.

There is a varied understanding of *linxing* spirituality among the three nurses in relation to the healthcare context. *Lingxing* spirituality connotes totally different meanings in the Christian world and the healthcare world. The conflict in the understanding between the nurses' two different worlds is illustrated in table 8.2 as follows:

	Lingxing, spirituality in the Christianity world	*Lingxing*, spirituality in the healthcare world
PC	Related to church About faith	"meditation" "cosmic natural therapy" Christianity and other beliefs
SC	Related to the creator Seeking and "connecting"	"may or may not be" not sure "harder to care deeply if no religious faith"
KM	"Relationship with God" About "prayer, bible, church going" "Behavioral"	"about meaning of life" "transcendence" "naturally manifest in daily life"

8.2 *Lingxing* understanding in the nurses' Christian and healthcare world

Despite the fact that there is a varied understanding of *lingxing* spirituality within the healthcare context, which confuses the three nurses, spirituality as *xinling* and *lingxing*, each carries its own set of meanings with specific roots. When spirituality is related to caregiving and is about the needs of patients, the understanding is clear. Spirituality is love, it is about the person and about God. It is the love of God which connects the person and God.

8.42 Conflict between the healthcare system and Christianity as a shaping influence

The healthcare system and Christian influences are both important in shaping the identities, understandings of spirituality, and practices of the three nurses, as seen from each of their narratives. There are differences in their understanding of spirituality concerning the person, God and love between the two worlds, however. For the three nurses, their dual identities as nurses and Christians manifests the conflict between these understandings. I consider that the confused understanding of the spiritual care of a person within the healthcare system aggravates the conflict between the two influences. Yet the underlying root of the conflict is that spirituality as love and spirituality as being about the person separate spirituality from its root in the loving God.

For all three nurses, there is a different understanding of spirituality to do with God in the healthcare context and within Christianity. The dual identity of a Christian nurse exemplifies the conflict between the two influences. Similar to the chaplains, God is an important and common theme in the three nurses' lives. Christianity is an important influence in shaping their understanding of *lingxing* spirituality, i.e. about God. For the three nurses, spirituality to do with God can be understood on three levels. Firstly, there is cooperation between God and the caregiver, i.e., God co-operates with the nurse caregivers. For PC, God works and "expresses through" Christian nurses like her. For SC, God is present among the cared-for and the caregiver, while KM has been so touched by the Holy Spirit that she feels blessed. Secondly, God is in the caregiving. They all experience God's love and God's participation and presence in the caregiving process (PC, 113; SC, 28, 204; KM, 196,199). Thirdly, they have a dual identity from God as Christian nurses. PC is God's love facilitator, SC is God's representative and channel of God, while KM is sent by God to bless. As God's love is so important in their lives, all of

them want to share about God with their patients. This includes “evangelizing” and “praying” (SC, 22-25); doing some linking by saying, “Jesus loves you” and “prayer” (KM, 187-189; PC, 107-110). The Christian influence is important in shaping the three nurses’ understanding of the spirituality of God. However, they are not free enough and experience frustration as Christian nurses. The dual Christian-nurse identity exemplifies the conflict between the healthcare system and Christian influences.

There is confused understanding about the spirituality of the person within the healthcare context. This further deepens the conflict within the three nurses. As mentioned above, the healthcare influence has shaped their understanding of the spirituality of the person. When spirituality is about the person, it is about emotions, worries and also the thoughts and beliefs of the patients. However, the three nurses all find that within the healthcare context, there is a confused understanding of the spirituality of the person. PC finds that nurses have a “fear of not knowing how to respond” to the spiritual needs of patients. Therefore, they readily “leave”, “dare not” stay with patients, and just make the “referral” to chaplains. SC has seen malpractice in the personal caregiving of other nurses. This causes conflict and fear within her also. KM finds that “not many people really show concern” about spirituality in the healthcare context. Nowadays, spiritual care is just left at “drawing curtains”, “providing privacy” and asking whether patients have any religious faith when doing a spiritual assessment. There is a gap between the importance of spirituality in the world of the literature and the phenomenological world.

There are different understandings of God and the person between the two worlds. This leads to frustration and difficulty for the Christian nurse. In the following paragraphs, I argue that the underlying cause of the conflict is because spirituality in the healthcare context has been separated from its Christian root.

For the three nurses, spirituality is about love. They all emphasize a kind of natural loving care to their patients. Their understanding of spirituality as love is the core love of God, i.e., God loves people like them. They are called by love to practice the loving nursing care of a person naturally. God’s love can be continuously experienced in their natural loving care every day. For example, PC believes in co-operating with different personnel to provide a loving care of “continuing liaison”, which aims at comforting

patients naturally and share about God naturally. KM sees the patient as a whole person in different relationships, and she practices natural loving caregiving by building natural relationships with patients. SC's loving care is the compassion of God. It is "simple and natural" for her because God calls and loves her. However, for all three nurses, their passion for practicing natural loving care is in conflict with the actual practices within the healthcare context. The understanding of spirituality in relation to a person's universal need for love has been separated in the healthcare context from its Christian root in love from God. There is thus a conflict between Christian and healthcare influences in the understanding of spirituality as love, about the person and about God. Within the healthcare context, love towards a person or a person's need to be loved has nothing to do with its root in the loving God. The caregiving love of the nurses' for the person thus becomes dis-integrated and fragmented.

The confused understanding of spirituality as love in the healthcare context has deepened the tension within the Christian nurses. On one hand, they would like to care for the person with love. On the other hand, this does not synchronize with the healthcare milieu they serve every day. They would like to comfort a person naturally with God's love, but love as the love of God is not considered nursing and "may not be allowed" within the healthcare context. This conflict is manifested as frustration, difficulty and struggles for the nurses.

The influences of both healthcare system and Christianity are important in shaping an understanding of spirituality and its practice. However, the conflict between the two is exemplified in the dual identities and struggles of the Christian nurses.

8.43 Confusion within Christianity

Christianity is an important influence in shaping the nurses' understanding of spirituality as love, as being about the person and as being about God. However, the confusion within Christianity also deepens the conflict within the nurses as Christians.

The three nurses are passionate Christian nurses. They are passionate about serving as nurses with natural love and doing more for God. They also told me that their entrance into the profession was not an accident, but God's plan. When I shared my analysis with

PC, she said that it took her back to her history of caregiving as a nurse. She strongly agrees that it has been God leading her through these years. She is thankful to God for giving her the strength to sustain her through all the difficulties. From SC's narrative, it is clear that nursing is her calling. The last time I met SC, she updated me that she is now working part-time as a night nurse and serving at two chaplaincy offices as a volunteer. Regarding her calling and experiences in caregiving, she wanted to conclude, "May God's will be done". KM is the youngest of the three nurses, but she is just as passionate in her caregiving. When I shared my data analysis with KM, she was moved to tears. She recalled clearly the blessing she received from God. She shared with me her recent experience of caring for a patient who suffered greatly. She did not give up and supported the patient in different ways because she wanted to send blessings in the same way that she had received blessings from God. The patient was cured at last and thanked her, saying that she would remember KM's caregiving for the rest of her life. I consider that for all three nurses, Christianity has been an important influence in shaping their passion to understand and practice caregiving. It has also been an important influence in carrying them through years of difficulties and changes in the healthcare milieu. However, the confusion within Christianity about spirituality, namely concerning the person and love, also deepens the conflict within the three interviewees as Christian nurses.

KM finds that there are differences in practice among Christian nurses depending on their understanding of *xinling* care. Some might fulfill their responsibilities, but they do not think about how to care for the person better. She finds that there are variations within the church about what is right, and what it means to be a good Christian. These variations are confusing for KM and are the frustration of Christian nurses. SC also considers that there are different kinds of Christians. The "different perspectives" on *xinling* care are "complicated" and make her confused as a Christian nurse. At our last meeting, SC shared her confusion when we talked about her calling as a nurse. She still found herself confused about whether to leave nursing or not, because of the differences within Christianity about the meaning of love. Some Christians think that people can show their love to God in whatever vocation they have. Yet SC was advised that when Christians have great love and passion for God, they should leave their jobs and serve whole-heartedly. The confusion within Christianity about love between persons and God is

confusing to her, causing her to feel uncertain about her calling and relationship with God. When I shared my data analysis with PC about her role as a Christian nurse, her immediate reflection was that she might not be the standard Christian nurse. She said that she found there were many different types of Christian nurses. PC emphasized team-work in caregiving, yet she sometimes feels disappointed and "cannot figure out" the behaviors of some Christian nurses.

Christianity is an important shaping influence. It has shaped the nurses' understanding of spirituality and their passion about practicing natural loving nursing care. Christianity also deepens the conflict between the healthcare and the Christian influences. The confusion within Christianity about spirituality brings challenges to the identity, calling and role of a Christian nurse.

8.44 Culture shaping influence

Thus far, I have discussed how, for the three nurses, spirituality is about the person, about God, and about the love between a person and God. I have argued that both the healthcare and Christian influences have been important in shaping their understanding, yet they are in conflict. The core of the conflict is that spirituality has been separated from its Christian root in the healthcare service. The confusion within Christianity deepens the conflict for the three nurses. In the following section, I discuss the dynamic interaction of cultural influence with these two other influences of healthcare system and Christianity.

For the three nurses, spirituality is love, i.e., it is about a personal relationship with God and the relationship between persons. Similar to the three chaplains, relationship is an important common sub-theme for the three Christian nurses, who are all Chinese. For example, PC considers that interpersonal love and the God-human relationships are the spiritual needs of a person. KM understands spirituality as "*Shangtian, tiandi*" (i.e., heaven and earth). Therefore, the spirituality of the caregiver is about personal relationship with God through connecting the self with the world and with God. The disturbance of any dimension in the relationship can affect a nurse's caregiving. SC considers that *xinling* care is "about the relationship between" God and the person. Increased understanding and a breakthrough in family relationship enhanced her being as a caregiver. In her practice, caring for relatives is her focus. As I mentioned in chapter

seven, in the general discussion about the three chaplains, Chinese culture sees a person not as an individual, but as constituted by relationships. The understanding of spirituality as natural loving relationships includes the relationship between the person and God, the person with other persons, and the person with the world. This view is shaped by the Christian influence as well as by Chinese culture. Chinese culture is important in shaping the spirituality of a person in a set of relationships. However, the hierarchical nature of Chinese culture is sometimes in conflict with the non-hierarchical natural loving relationship between persons shaped by Christianity. There is a conflict between Christianity and cultural influences. The conflict may not be that obvious in PC and KM, but it is clearly manifested in SC's narrative.

SC has *Chiu Chow* Chinese origins. As I mentioned in MF's narrative, women have "no say" in *Chiu Chow* culture. SC is not allowed to "express" herself. She naturally withdraws out of hurt and to avoid conflict. However, this natural withdrawal from another person is in conflict with her natural and non-hierarchical loving relationships with people as a Christian. The conflict between the cultural and Christian influences deepen SC's frustrations as a Christian nurse. When SC left her hospital nursing service, she clearly admitted that she could not find space to provide the kind of Christian nursing care she wanted to give. Moreover, the seniors expected her to play a leading role, which she felt herself unready for. She had "fear" about "expressing" her feelings and also became frustrated by other inter-personal conflicts. The Chinese cultural influence deepened the conflict between her healthcare world and the Christian world. This was manifested in her health as "lostness" and "sickness". On the one hand, she wanted to have natural loving relationships with persons. On the other, she withdrew from the inter-personal conflicts in her workplace. The Chinese cultural influence aggravated the conflict between her two worlds.

The hierarchical inter-personal relationships of Chinese is in conflict with the natural and non-hierarchical relationship between persons in Christianity. Chinese cultural influence can aggravate the conflict between the healthcare and Christian influences. This was illustrated in SC's "lost" narrative. The Chinese's "more and loving" culture, as

explained below, is also in conflict with the love of God in Christianity. I consider that this conflict can cause tiredness and frustration in Christian nurses.

The three nurses are Chinese Christians who see themselves as being in loving relationships with God and with other persons. All of them have their own special identity from God. They continue to experience God in their lives and in their nursing caregiving. It is interesting to find that all three nurses want to be "more" because of this love with God. There is a positive relationship between love and more, i.e., the more love there is in the relationship, the more the person wants to do. For example, because of PC's beliefs as a Christian nurse, she considers that she "should care more", "do more", "facilitate" more, in order to show God's love and to "hold" patients more when they are upset. Learning more, serving more and understanding God more through nursing have become SC's goals in life. KM also believes that "there is something I can help more" and wants to "do more to help". This "more" theme occurs repeatedly among the three nurses. They experience the love of God in their lives. They want to serve and do more. I consider that this strongly echoes the "doing more" culture of the Chinese. It is common among Chinese that love is expressed by doing instead of by verbal expressions. Children are expected to study more out of filial piety and for the love of their parents. The father does not express love, but instead works hard as the head of the family for more bread. The mother always shows her love by cooking more food. She will remind her children to put on more layers in winter, eat more and drink more soup to stay healthy etc. Love is expressed by "doing more" in Chinese culture.

The three Chinese Christian nurses all have loving relationships with God. These loving relationships cannot be separated from the love between persons and between the person and the world. The Chinese influence is important in shaping the nurses' expressions of love to God and love to patients by doing more in the caregiving. This "more" and loving in Chinese culture deepens the conflict between the healthcare system and Christian influences. On one hand, the nurses want to share more of God's love and help the person more with love. On the other hand, there is confusion in their understanding about the bestowal of love to patients in the healthcare milieu. They emphasize the importance of relationships in Chinese culture, but they become increasingly frustrated about the

confused understanding of spirituality, both in the church and within the healthcare context.

I consider that the Chinese cultural influence deepens the conflict between the healthcare system and the Christian influences. The more loving the relationships the nurse caregivers have with God and with persons, the more they want to do, but the more frustrated they become.

8.45 Clinical Pastoral Training shaping influence

Despite the fact that CPT is not accredited training for nurses, all three nurses completed the study within a year. They all wanted to learn more about spiritual care and hence joined the training. They had to make extra effort and use their own time for study after work. Even though KM had some difficulties with her supervisor, all of them found CPT beneficial. The CPT influence has been important in shaping their understanding of spirituality about persons in relationships and their understanding about *xinling* or spiritual care. CPT influence has also been important in helping them resolve the conflicts between the different influences.

In order to provide good spiritual caregiving, the three nurses all agree that the person of the caregiver is most important. Spiritual caregiving is not only about skills. It is about the heart and the being of the person. The person needs to be nurtured and their being has to grow. CPT is important in nurturing the person so that growth is possible. All of them have experienced growth in the form of an increased understanding of the self, enhanced understanding about relationships, and increased understanding of *xinling* care. These three perspectives are inter-related; they interact with one another and are manifest as the growth of the self.

Firstly, an increased understanding of the self as a person includes an acceptance of the need within the self (KM: 121-122; PC: 143; SC: 10); new discovery of different parts of the self through wider and more perspectives from others (KM:175, 183; PC:41-42; SC: 58,99); and a different understanding of the past (KM:184; PC: 140-141; SC: 100). CPT is important in shaping a healthy self for a healthy practice. The three Christian nurses have been caught in the conflict between the different influences and have become

frustrated. CPT has been important for the acknowledgement by the caregivers of their own needs as people. The new discovery of their "being" becomes an important resource for a caregiver in difficulties.

Secondly, through different relationships established in CPT, there is increased understanding of the self and others. CPT has thus shaped PC's understanding that the caregiver and the cared-for are two "equal" subjects. Caregiving it is not a relationship between a strong professional and a weak patient. Caregiving is team work and does not depend on individual service. Therefore, she can "do more" by "liaising with" different professionals in the team. Her spiritual care model is a continuous and liaison caregiving model. SC discovered how her family relationships have shaped her inter-personal relationships. After a breakthrough in relationships with her family members, she has become more positive that she is able to "express" herself. When experiencing "complicated" personal dynamics, KM is able to choose whether to listen to criticism or not. She is able to differentiate the self from others. CPT has been an important influence in soothing the conflict between the different influences. All three nurses have acknowledged a confused understanding of spirituality in relation to love, persons and God within the healthcare context. By engaging in a set of different relationships in CPT, they have had a chance to explore inter-personal relationships and their relationship with God. In return, this has informed their understanding of spirituality as love between the person and God.

Thirdly, there is a paradigm shift in their understanding of *xinling* care. For PC, *xinling* care is not about problem solving anymore. She can care by just listening and being genuinely present with patients. For SC, spiritual care is not necessarily about evangelizing and talking. It is about caring by just listening. For KM, although she admits that there has not been much difference in her caregiving, the increased understanding of *xinling* care provides her with the direction and theory of caregiving. CPT is important in shaping the understanding of *xinling* care as accompanying, presence, togetherness, and love, rather than evangelizing. When the nurses want to do and help more, this enhanced understanding of *xinling* care is important in soothing the conflict between Christianity and cultural influences.

Conclusion

The understanding of *xinling* spirituality in relation to caregiving is similar among the three nurses. Yet the understanding of *lingxing* spirituality is different in the Christian and healthcare contexts. I consider that there is conflict between the two influences because spirituality, as love in the God-human relationship, has become separated from its Christian root. The confusion within the healthcare service and within Christianity can aggravate the conflict. I have also argued that the Chinese cultural influence is important in shaping the self in a set of relationships. In understanding the needs of the caregiver, the "more" and loving Chinese culture cannot be neglected. It challenges the being of a person and causes frustration within. CPT is an important influence in shaping and nurturing growth in the being of the caregiver, and helps to resolve the conflict between the various influences.

Section III: Discussion, Recommendations and Conclusion

Chapter 9

Discussion of Data: Answers to Research Questions

Introduction

This chapter opens the final section of the thesis, in which there are two chapters. Chapter 10 is the factual and conceptual conclusion. Before the final conclusion, this chapter 9 is a discussion of the data. I pull together the data analysis of the chaplain group in chapter seven with that of the nurse group in chapter eight. The purpose is to answer the research questions:

(1) What understanding of spirituality is held by Hong Kong Chinese spiritual caregivers with reference to CPT?
(2) What kinds of influences might have shaped the understanding of spirituality and the practice of the caregiver?

On the basis of the insights provided by my fieldwork, I set forth some recommendations for my professional practice in Clinical Pastoral Training. This becomes the answer for the third research question:

(3) How might Clinical Pastoral Training address the needs of the spiritual caregiver?

9.1 The Understanding of Spirituality Within CPT

When I first approached the topic of spirituality, I hoped to find a common understanding of the term in order to reduce confusion in the healthcare service. I have to admit that both in the literature and in my evidence from the empirical research, there is no common and authentic definition for spirituality within Hong Kong CPT. The two Chinese terms for spirituality, *xinling* and *lingxing,* further confuse my participants. Understanding spirituality in the local healthcare context is more complicated and confusing than I originally expected. The confusion is so great, in fact, that the nurse group prefers the term "holism" to spirituality as *xinling* and/or *lingxing*. This choice echoes the debate about the validity of spirituality in the healthcare context, where it is argued that as the

meaning of the word spirituality is so vague, it really has no legitimate use or value (Paley, 2008). Swinton and Pattison (2010, pp. 226-236), argue, however, that the importance of a language lies neither in its clearness nor its specificity. It is more significant to understand the "function" of the language and the "context" within which these interpretative actions take place. My research findings agree wholeheartedly that the value of spirituality is in its "performative" and "expressive" nature.

Despite the fact that my participants' understanding of spirituality is vague, varied and confused, there are similarities between them. It was revealed that the theme of spirituality for the nurse and the chaplain is the same: it is about person, God, relationships and love (i.e., the relationships between person and person and between God and person). When spirituality is about relationships, it refers to at least five dimensions for my informants. The five dimensions are the God-human relationship, intra-personal (with self) and interpersonal (with others), corporate (relationships in groups, family, church, and institutions as team and members) and spatial relationships that is, relationship with the world, heaven, and the ultimate in the different stages of life (Lartey, 2012). My evidence shows that, firstly, the understanding of spirituality has boundaries. Yet it is not non-referential and without value in the healthcare service (National Secular Society, 2009). Secondly, the vague description of spirituality is not its deficiency, but its strength, for it denotes the site of "void and absence" in caregiving (Swinton, 2010, pp. 228-229). My participants' understanding of spirituality as relationship and love denotes an "absence" in Hong Kong healthcare service. This echoes the views of Murray and Zentner (1989), and Tanyi (2002) who argue that love and connectedness have been downplayed within current treatment approaches, and need to be reclaimed in the healthcare context. Thirdly, my participants' understanding of spirituality as relationship and love reflects the Chinese cultural influence of seeing a person as a social being rather than a solitary individual (Astrow et al., 2001). Therefore, in treating health, a good *Zhong Yi* (Chinese medical doctor) takes into account the dynamic interaction between a person's internal and external worlds and the circular effect within the overall unified wholeness (Chan et al., 2006). In terminal illness, Chinese finds peace in relationships, including serving others and fulfilling

responsibilities (Mok, 2010). The understanding of spirituality as relationship expresses eastern holism, which sees the human person as inseparable from a set of relationships.

The value of spirituality lies not in the clearness of the term or the specificity of the language. The significance of spirituality is because of its ability to evolve and develop and be understood in sometimes very different ways (Sheldrake, 2007). My evidence shows that spirituality (*xinling* and *lingxing*) denotes a powerful set of meanings. My participants all connect *lingxing* spirituality with Christianity, guiding the practice of both groups. *Lingxing* spirituality is a concept deeply "embedded in a rich and contested [Christian] history of usage" (Carrette & King, 2005, p. 3). Even though there is a diversity of understandings of spirituality within Christianity, and the meaning is still developing, the task is to listen and to understand the "function" and "direction" of the language in the contexts (Swinton and Pattison, 2010, pp. 226-236).

My research findings allow me to draw this very specific conclusion. The understanding of spirituality within CPT is important, yet the sum of the understanding of *xinling* and *lingxing* is not equivalent to the reality of spirituality. It is crucial to understand the connotations of related concepts, the "task" they perform and the context in which they are expressed. The parts cannot be separated from the whole.

9.2 Dynamics of Healthcare, Christian, CPT and Cultural Influences

From my evidence, the healthcare and Christian influences are both important in shaping identity, the understanding of spirituality, and the attitudes and values of practice for my participants. However, the two influences are in conflict. The conflict is so severe that it leads to frustration and identity confusion, which reflects a lack of clarity and misunderstanding in the relationship between religion and spirituality in the healthcare context. Despite the fact that religion and/or spirituality have been affirmed and incorporated as important elements in recent healthcare services (Pargament, 2007; Oppy, 2012), there is still a confused understanding of both religion and spirituality in the healthcare service (Swinton, 2012). Spirituality and religion continue to be contested concepts. The relationship between them is also unclear. As Tacey (2012) would agree,

there are two dominant approaches to the understanding of spirituality in relation to religion within the healthcare profession. Firstly, spirituality is able to exist without religious traditions. Secondly, there is a close association of religion with spirituality. I consider that for my participants, spirituality and religion (Christianity) cannot be separated. Religion (Christianity) is not only the important shaper of beliefs; it promotes positive self-perceptions, regulates lifestyles, provides coping resources, and generates positive emotions (Ellison and Levin, 1998). In important moments of life, spirituality expresses a person's search for meaning through their beliefs in religion (Association of American Medical Colleges Report, 1999). The limited information produced through my fieldwork suggests that spirituality and religion (Christianity) are closely tied to and dependent on each other. However, spirituality and religion (Christianity) are regarded as two distinct concepts in the healthcare context (Schneiders, 2000). There is a separation of spirituality from its religious (Christian) root, its past and history. The beliefs, the identities and the practice of my informants becomes disintegrated and confused as a result.

The importance and effect of cultural influence is greater than I had expected. From my evidence, the cultural influence naturally shapes my participants' understanding about persons and relationships, affecting their past beliefs and their present selves, and providing directions for growth for the future. Cultural influence is subtle and shapes a person's life for an extended period of time such that the person may not be aware of. It integrates well into a person's beliefs and reveals its effect in crises (Li, 2011). The limited information from my fieldwork also suggests that the cultural influence deepens the conflict between healthcare and Christianity. This echoes the understanding of Hofstede (2001, 2005) that the four dimensions of culture namely, power distance, uncertainty avoidance, individualism vs. collectivism and masculinity vs. femininity express the fundamental dilemma of the human being. The high masculinity and collectivism in some of the Chinese cultural origins of my participants is in conflict with their Christian and healthcare (western) beliefs and values applied to the understanding of persons, God and the world. There are different ontological perspectives on human beings and the world between west and east (Kwan, 2016). My information allows me to draw this very specific conclusion: that the conflict between the healthcare and Christian

influences is because of the separation of spirituality from its past and its root. This conflict is aggravated in the Hong Kong Chinese healthcare context because of the differences between eastern and western holism.

Clinical Pastoral Training, CPT is found to be a positive influence for my participants, both in terms of their understanding of spirituality and their practice of caregiving (doing) associated with the being of the person. My evidence shows that CPT can enhance the growth of persons, expressed in acceptance of their limitations, acceptance of their needs, acceptance of the past, and their embrace of a new and wider perspective of the self. The growth of the self in return makes a difference in the practice and understanding of spirituality. As Cabot (1947) would agree, the growth of souls is indeed the decisive mark of the sacred in a human being. Boisen (1951) also affirms the importance of exploring one's inner world, so that one can be sensitive to others' struggles in life and death. My limited information reveals the increased understanding of the caregiver as a person is closely related to an enhanced understanding of *xinling* spiritual care within CPT. It is interesting to note the different understandings of spiritual care found between the two groups. For the nurse respondents, there is a paradigm shift that recognizes spiritual care is not about problem solving, evangelizing or talking. It is about listening and caring the cares of patients. For the chaplain respondents, the paradigm shift is that spiritual care is not human work, but God's work. God is in control; God works within, God calls and equips the caregiver. My information does not allow me to account for that difference. Yet, I can draw the specific conclusion that CPT is a positive influence in the growth of the person, enhancing an understanding of caregiving through clinical practice.

The findings from the empirical research allow me to conclude that the understanding of spirituality among Hong Kong Chinese spiritual caregivers is vague and confused. Within this complex set of understandings, four related concepts are found, relating to the understanding of spirituality as being about the person, about God, about relationships and about love. The dynamics of the four shaping influences: the healthcare system, Christianity, CPT and cultural factors, are important in shaping the spiritual caregivers' understanding of spirituality and their practice.

The thesis has produced greater understanding of and clarification about spirituality within Hong Kong Clinical Pastoral Training. The originality of the thesis is that it brings together different influences that have previously been kept apart (Trafford et. al, 2008). I have offered a more dynamic and generative understanding of the different influences than exists in related literature. I consider the study to be significant, because it extends the existing body of knowledge and evidence-based research concerning Clinical Pastoral Training in the Hong Kong Chinese context.

9.3 CPT in enhancing the confused understanding of spirituality

Thus far, I have answered the first two research questions. The following paragraphs constitute the answer to my third research question. From the empirical research, Clinical Pastoral Training was found to be a positive influence for my participants, both in terms of their understanding of spirituality and their practice of caregiving (doing). My research thesis provided me with the insights to affirm the value of CPT for Hong Kong health caregivers in addressing their confused understanding of spirituality, and their identity confusion, which is caused by the conflict between the different influences.

CPT can enhance the understanding of spirituality by developing a kind of Chinese culturally-sensitive language of spirituality. Chinese language related to the spirit *ling*, including *jing* (□), *shen* (□), *xin* (□), *qi* (□), *zhi* (□), *hun* (□), *pao* (□) *xing* (□), *yi* (□), and *ziran* (□ □), should be discussed and encouraged for use in the caregiving practice (Kwan, 2016). CPT can also enhance trainees' understanding of Traditional Chinese Medicine (TCM), which has shaped local patients' thinking about health. I recommend that the *qi* and *yin yang* concept in TCM that have been rejected as heresy within Christian-based CPT should be included as part of Chinese culture. Daoism, which is more a philosophy of TCM than a religion, needs to be understood in the right context (Ai, 2006, Chan et al., 2006). It is important for CPT to enhance trainees' awareness of cultural influences on Chinese patients in their caregiving. Traditional and cultural teachings, as well as spiritual practices are unconsciously integrated into people's language in daily life, affecting their beliefs and helping them create meaning in suffering

(Mok, 2010; Li, 2011). CPT needs to cultivate a kind of culturally-sensitive spiritual care practice within the local context. This can be done by promoting the use of the Chinese language of spirit, the understanding of Chinese beliefs about life and death and the understanding of TCM concepts about health.

From the empirical research, it was clear that my participants found theological reflection important. This corresponds with Boisen (1951), who encouraged caregivers to explore and reflect on their own inner worlds and theologies. My evidence shows a third issue of importance in theological reflection. Through action/reflection, with special relevance to Chinese culture, the caregivers' understanding of spirituality as relationship can be enhanced. In Chinese culture, as mentioned before, the understanding of a person, whether it is the supervisor's understanding of the trainee, or the caregiver's understanding of the cared for, cannot be separated from the relationships of a person in the family, the group, with the world, and within the culture. Therefore, the purpose of theological reflection about a person's life is to understand not only a person's narrative, but also their five dimensional relationships within the culture (Lartey, 2003). CPT can enhance understanding of spirituality by cultivating theological reflection upon the trainees' own living human document in their various relationships. When the trainees review and reflect upon their lives as a whole in CPT, their caregiving will become more culturally sensitive.

9.4 Role of CPT in Addressing the Conflict Between Influences

9.41 Reflection on the Six Caregiving Models

As a CPT supervisor, I meet students from different walks of life. I often meet them when they are in their life struggles and seek to facilitate their growth in addressing their strengths and weaknesses. Through my research, I found that my six informants each had their own approaches in providing caregiving, which can be broadly characterized into six different caregiving models.

The six caregiving models provide me with a framework that I can refer to during my supervisory practice. Each model of practice can be used to understand the individual's

strength and their difficulties in practice. It provides me with at least six different patterns of practices which are based on the beliefs, values and attitudes in caregiving. It not only heightens my sensitivity to my students' needs here and now, it also reflects their being so that I can nurture their growth according to the individual's temperament and needs. However, I have to be careful not to overgeneralize and stereotype my students as belonging to a particular model. Even if some of my future students' practice may present some similarities with the mentioned practicing model, every single one of my informants and students is an individual and a unique person. The caregiving models should not oversimplify the understanding of a whole person. Therefore, the model analysis derived is only a broad framework for reference.

Upon deeper reflection of the caregiving models, I consider that the difficulties in practices are due to the conflict of the different influences. The dynamics of the different influences behind each model are more complicated than I imagined initially. The conflict of the influences is so intense that it challenges not only the practices but the identities of the caregivers. They have an identity crisis or identity confusion which is summarized in table 9.1 as below:

	Caregiving Model (CM)	Challenges
PW	Psycho-spiritual CM (p.89)	Pastoral Identity Crisis (p.91-92)
SY	Two-tool connecting spiritual CM (p.99)	Confusion within Christianity and tension between the Christianity and healthcare influence causing disintegration in practice and pastoral role confusion (p.101-102)
MF	Level and step spiritual CM (p.108)	Conflict between the cultural, Christianity and healthcare influences leading to fear in caring male patients and struggles in

		pastoral caregiving (p. 111-112)
PC	Continuing liaison nursing CM (p.133)	The identity of a Christian nurse in the caregiving team who also has her own religious belief and fear in facing life and death (p.135-136)
KM	Natural nursing caregiving CM (p.142)	Identity confusion as a Christian nurse (p.144-145)
SC	Juxtaposition nursing / spiritual CM (p.153)	Caught between the Christianity and healthcare influence leading to Identity confusion (p.153-154)

Table 9.1 Challenges of the caregivers reflecting from their caregiving models

The conflict of the different influences caused the difficulties in practice and challenges the identity of a caregiver's being. The more deeply I reflect, the more I am amazed at the complexities and diversities of a sacred person. Nevertheless, my limited evidence showed that CPT was a positive influence in addressing the identity crisis (p.89-91; 100-101; 110-111; 122-124; 133-134; 146-147; 155-156; 167-169).

9.42 CPT in Re-shaping the Identity of the Caregivers

Drawing on the insights provided by the research, I would suggest CPT is able to address the conflict between the different influences by reshaping the identity of the caregivers, namely, the identity of a sacred living human being, the identity of a practical theologian and an authentic identity as God's children. This identity re-shaping can be done at different CPT units which will transform my supervisory practice in the future.

I agree with Boisen (1951) that every living human person is unique, important and sacred as a living text. The deepest experiences of a person, whether it be their struggles with spiritual life, psychological perspectives on grief, interpersonal conflicts, family relationships or illnesses, all demand the same respect. No matter how strange the

language might be, it is worthy of being heard and understood. Nouwen (1979) agrees that a living human person has a sacred identity. The person is also wounded with needs and limitations. In my professional practice, I affirm the value of CPT in restoring the identity of a living human person as sacred, but with limitations. CPT can address the personal struggles of the healthcare person by cultivating theological reflection about the self in the conflict between the religious and healthcare worlds. This can enhance self-understanding through a kind of awareness of the different influences.

The future development of Hong Kong CPT might follow the U.S. example and be open to people of multi-faiths. Other healthcare persons besides chaplains and nurses might be expected to take CPT in order to practice caregiving in its physical, psychological, spiritual, cultural and environmental aspects (Hong Kong Hospital Authority, 2001). In my professional practice, I affirm the value of CPT in addressing the identity confusion of different health caregivers, and in restoring their identity as practical theologians. This is to emphasize the interaction between theory and practice. Whatever the role of the healthcare professional, it is important for the caregiver to seek the identity as a practical theological endeavor who has a clear praxis with four clear "core tasks", namely, the descriptive empirical task, the interpretive task, the normative task and the pragmatic task (Osmer, 2008, p.4).

At last but not least, I consider that the restoration of authentic identity is especially important in Hong Kong CPT. From the limited information produced through the fieldwork, the patriarchal and high masculinity Chinese culture can result in a high power distance from God, the heavenly father (Hofstede, 2001). It is not easy, but it is important to accept that we are loved as we are, female or male, weak or strong, good or bad. This corresponds with Nouwen's (1969) view that whatever task and identity a person has, it is important to reclaim authentic being in the world; that is, being loved unconditionally by God. We are created and accepted as we are and we are the beloved children of God. This authentic identity as God's children is not based on gender or what we accomplish.

9.43 Transformation in Supervisory Practice at Different Levels

The research has widened my horizon and transformed my own identity. I also face the conflict of the different influences. This transformed self will be more sensitive to the conflict arising from the dynamics of the different influences which have been shaping the identity of my students. The identity re-shaping can be done at different levels in my supervisory practice.

Firstly, I affirm the value of CPT for ministers, chaplains, nurses, social workers, counsellors, therapists and doctors. CPT is not professional training in skills and knowledge. It is about developing acute observational and listening skills for both the expressed and unconscious aspects of the lives of living human beings. CPT is also not training for Christian evangelism, or later on, broad-spectrum evangelism (Lawrence, 2016). It is training in listening in a culturally-sensitive way so as to understand the person as sacred and authentic. In my supervisory practice, listening to struggles has to be emphasized. In grouping students, I will put students with different backgrounds in a group to promote diversities. It is good to mix students with a strong healthcare background with students of a strong theological background. This aims to promote dialogue and listening among the group. Different theological traditions can be challenged and different denominations in Christianity in a group can widen the perspectives of the students and enhance integration. It is also important to cultivate a compassionate and caring milieu in the group, within the self, and between one another so that the trainee caregivers can be seen and touched as living human persons. I would like to promote the spirituality of caregiving not only to patients, but also among and between the caregivers. Therefore, different CPT centers are encouraged to gather together for mutual support and learning. Supervisors can encourage students to have explicit discussion of their different patterns of practices and differences in the identity challenges. This will help them critically reflect on their understanding of their position and that of others in the group.

Secondly, I consider that the growth of Hong Kong CPT can only be enhanced with the co-operation between supervisors, chaplains and healthcare professionals of different backgrounds. CPT supervisors should be encouraged to work more closely with the field instructor. There should be debriefing session with the students together after the

fieldwork. The practicing model of each student has to be understood as it can easily reflect the challenges and difficulties s/he is facing. Students are also encouraged to sit in the hospital meeting including the palliative care team conference for mutual understanding and communication among different disciplines in caregiving.

Thirdly, I claim the importance of spiritual discipline to enhance awareness of God's unconditional love so that a person might be touched by "an all-transforming love" (Nouwen, 1988, p.75). This is to make available inner space so that God the Spirit can pervade and unify the whole person. It is to provide a way for people to experience the presence of God and be ready to respond. Therefore, spiritual discipline and spiritual discernment will be emphasized during the individual supervision or inter-personal relation (IPR) section. The caregiver is encouraged to share their mission and calling in IPR. Through the group dynamics, the individual can attain different perspectives in addressing their different roles and identities. Based on the understanding of the different caregiving models, I suggest supervisors to encourage the Christian nurse caregivers that being a good nurse is already an important way of living out God's mission.

Conclusion

This research has provided me with insights into my professional practice, which becomes the answer for the third research question. The fieldwork evidence allows me to conclude that Hong Kong spiritual caregivers have a confused understanding about spirituality, difficulties in practice, and identity crises. CPT can address the caregivers' confusion by developing a kind of Chinese culturally-sensitive language in the practice and in action/reflection, with an emphasis on relationships within the culture. CPT can help to heal people's identity crises by cultivating the identity of a sacred living human, the identity of a practical theologian, and an authentic identity as God's children. These insights prove invaluable in my future professional development, and in my work with other healthcare professional and CPT supervisors as outlined above, which is aimed at enhancing the growth and life of the caregiver.

Chapter 10

Conclusion

Introduction

At the beginning of this thesis, I suggest that the portrait of Hong Kong Clinical Pastoral Training (CPT) is mixed and contradictory. Despite the recognition of the importance of chaplaincy or spiritual care in the healthcare context, the role and task of CPT as theological education or professional training, for Christians or persons with other religious faiths, or for pastors or other health caregivers, is not clear. Therefore, the purpose of the thesis has been to explore local training amidst this confusion. This chapter is a brief overview of the entire thesis, focusing on the outcomes of the research.

Through my professional interaction with the trainees, I find that there is a dilemma in their caregiving practice and an identity confusion that reflects a lack of clarity about their understanding of spirituality and the relationship between religious care and spiritual care in the healthcare context. From the point of view of a CPT supervisor, this research seeks to discover how CPT might address the needs of spiritual caregivers, so that they might develop a healthy being and a culturally-sensitive practice. There is a knowledge gap in caregivers' understanding of spirituality within CPT, and about the interplay between the different shaping influences, that is, the healthcare system, Christianity, CPT and cultural factors. I used qualitative interviews to seek the experiences and perspectives of six Hong Kong Chinese Christian spiritual caregivers who have finished at least one unit of the training. Based on their answers to the research questions in chapter 9, the following paragraphs are the factual and conceptual conclusions which demonstrate the contribution to knowledge and to my professional practice.

10.1 Factual and Conceptual Conclusion

The empirical research reveals the understanding of spirituality by Hong Kong Chinese spiritual caregivers is vague and confused within CPT. Themes of spirituality are found

to be about the person, about God, about relationships and about love. The four influences that have shaped the caregivers' understanding of spirituality and their practice are the healthcare situation, Christianity, CPT and cultural factors. The research has provided me with insights for my professional practice. Thus CPT might be able to address the confused understanding of spirituality by developing a kind of Chinese culturally-sensitive language for the caregiving practice, and action/reflection with an emphasis on relationships within CPT. CPT might resolve the identity crisis of Hong Kong spiritual caregivers by cultivating the identity of sacred living humans, the identity of practical theologians, and authentic identity as God's children.

My research provides sufficient evidence for me to conclude that the understanding of spirituality within CPT corresponds with Swinton's view that the value of spirituality is because of its "performative", "expressive" and evolving nature (2010, pp. 228-229). The four influences are dynamically interrelated and interdependent in shaping the caregivers' understanding and practice. The conflict between healthcare and Christian influences is because spirituality has pulled away from religion and become an "autonomous field" in the healthcare context (Tacey, 2012, p. 473). Chinese culture further deepens the conflict, which corresponds with Kwan's view that there is a difference between western and eastern holism (2016). CPT is evidently a positive influence in addressing the struggles of the caregivers' inner worlds, theological worlds and interpersonal conflicts (Boisen, 1951).

During the research I discovered spirituality was dynamically related to the four different influences. I treasured very much the process in which I had the honor to share the caregivers' spiritual experiences. I came to agree with the caregivers in the research, who subconsciously or consciously, work in a state of "spiritual conflict", which can be overwhelming and difficult. They have learned to draw resources from the different contexts, that is, healthcare, Christianity, CPT and the culture, and continue to commit to spiritual caregiving for the health of others. The additive nature of "spirituality" is a powerful attractant serving to reconcile the conflict within the person. Viewing spirituality and caregiving from this wider perspective has validated my commitment to my own practice. As a CPT supervisor, I see myself as caring for the caregiver. What I

and my participants do is about the core of life, about the person, about God, about relationships, and about love, and is therefore significant. It is life growing and work in progress under the mercy of the Lord. This research has helped me and the participants to bring the dynamics of spirituality to the surface and think about where we are and where we are going. In this way I hope I have been able to contribute, not only to the development of the training, but to my own growth and the growth of the caregivers as sacred texts and professionals.

The knowledge gap concerning Hong Kong Chinese caregivers' understanding of spirituality and the interplay between the different shaping influences has been filled through original inductive research. The modest contribution to knowledge is in the unique narratives of Hong Kong Chinese spiritual caregivers. From their experiences and those within my own professional practice, I "assimilate" different points of view, "synthesize" them and arrive at new understanding of spirituality and caregiving within CPT in Hong Kong Chinese context (Trafford, 2008, p.137). This is a kind of co-creation between the researcher and the participants, which goes from practice to theory to practice.

10.2 Agenda for Further Research

There are limitations to the research, which can themselves become a research agenda to be addressed in the future. My study is confined to Christian caregivers. The dynamics of other religions within the healthcare system, the culture and CPT are not known. This is an important future research agenda if CPT is to be opened to people from other religious faiths. Moreover, in my research, the nurse participants came from the same CPT center and the chaplain participants were serving at the same hospital. This might have limited the understanding of the training and the picture of chaplaincy caregiving.

My fieldwork transcripts indicated that respondents had some difficulty in explaining their responses to the dynamics of the different influences under which they operated. Since my study was inductive, the findings must be seen as provisional. Further studies could replicate my research questions and so build on my findings. This would lead to

deeper understanding of the dynamics of the shaping influences, or indeed identify other influences, so as to create a more complete picture for the training in response to the needs of the caregivers.

None of the above limitations undermines the evidence for a revised framework in the understanding of spirituality within the four contexts. Through conceptualization and original empirical research, I have made a contribution to my professional practice as a CPT supervisor in nurturing the growth of lives and the health in practice of Hong Kong Chinese spiritual caregivers.

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Appendices

Guiding interviewing questions

1 What is spirituality?

The questions help

1) To identify the conception of spirituality in student taking CPT (nurse/ chaplain
2) The role of spirituality in holistic health.
3) The relationship between spirituality and religion.

1.1 How would you define *xinling* and *lingxing*?
1.2 What do you think the difference between *xinling* and *lingxing*, religious faith?
1.3 What struggle do you have in a healthcare world of spirituality and your religious world of spirituality?
1.4 Do you think xinling care is important? How the patient may have changed after your visit or care? Give examples
1.5 What is your reaction when the Buddhist chaplain is included in the service?
1.6 What will you do when one is approaching death and still have not confessed? Why?

2 What is spiritual care?

The questions answer

1) The essence of spiritual care
2) The factors that can affect the practice of spiritual care
3) The conflict of spirituality and faith in practice

2.1 What you think of *xinling c*are/ *lingxing* care? What does *xinling* care mean to you as a nurse/chaplain?
2.2 How you would recognize a patient's spiritual needs? Give examples in practice
2.3 Please list some examples of *xinling c*are/ *lingxing* care?
Think of a time when you provided *xinling c*are/ *lingxing* care? Tell me about it/ the story.
2.4 What are the challenges in delivering *xinling c*are/ *lingxing* care? in your practice as a nurse / chaplain
2.5 How you have learnt to provide *xinling care/ lingxing care?*
2.6 What education you have received in this area? What may help in delivering *xinling* and *lingxing* care?

3 How CPT can change / strengthen the understanding and practice?
The questions help to answer

1) The efficacy of CPT
2) The ways that CPT can address the struggle in theory and practice
3) The integration of xinling and lingxing, spirituality and religion in CPT

3.1 How it helps you to understand human being/ self?
3.2 How it helps you to understand God in the religion?
3.3 How it helps you to understand people/ patients in the healthcare world?
3.4 What resources in CPT support you learning spirituality / giving spiritual care?
3.5 Tell me some of the ways that CPT centers / supervisor can support your practice of spiritual care in Chinese context?
3.6 How CPT helps you in the struggle of religion and spiritual, *xinling and lingxing*?
3.7 How do you know you have been successful in providing *xinling care/ lingxing care?*
3.8 How it might affect your role of nurse/ chaplain to continue practicing *xinling care/ lingxing care?*
3.9 What would you say about CPT to your own? Any new insight does it bring to you in your faith and your role / profession?
3.10 Is there anything else you would like to say about caregiving that we have not talked about?

Coding table: PW

	Code	Category	Sub-Category
1	"is heart"	A1a *XINLING LINGXING* RELATIONSHIP 1 A1b LIFE 2,3,4,5,6 b1 SELF 3,4,5,6. 9,10. 16,18. 20,21,22. b2 LIFE & DEATH 2. 15,16,19. 22,23,24.	A 1 SAME XINLING LINGXING
2	"meaning of life"		
3	"Value of a person"		
4	"Self-understanding"		
5	Self-image		
6	Needs as a person		
7	God is the creator	B CHRISTIANITY B1 GOD 7,8 B2 HUMAN PERSON 9,10,11,12,13	
8	God breathe in spirit		
9	Living person with spirit		
10	Spiritual need of person		
11	Personal relationship with God		
12	"seeking the creator"		
13	"responding here and now"		
14	"meaning of life" in faith	C RELIGION 15,16,17,18,19,28,29. 2,3,4,5,6. 31 C1 CHRISTIANITY 14,15,16,17,18,19. 7,8,9,10,11,12,13. 25,27. 30. D NON RELIGIOUS 15,16,17,18,19. 2,3,4,5,6.	RELIGION & NON-RELIGION ADDRESS SAME TOPIC
15	Life and death understanding		
16	Self-relationship with illness		
17	"Death is a topic of lingxing"		
18	Feeling in illness		
19	Beliefs about life		
20	Hope of person	E TOPIC OF LINGXING 20,21,22,23,24,25,26,27. 3,17	
21	Peace		
22	Life control		
23	Life questioning: any creator		
24	Fate determined or luck		
25	God leads and guides in life		
26	"Religion is a topic of lingxing"		
27	"live out the faith"		
28	"religion is philosophy"	F DIFFERENCE BETWEEN RELIGION AND CHRISTIANITY 28,29,30,31	
29	"religion is understanding and explaining life experience"		
30	"Christian faith is relationship "		
31	"religion is not about the relationship between the self and the world"		
32	"keep company"	G1 B: *XINLING* CARE: TOGETHER32,33,34,35. 70	
33	"listening to patients' need"		
34	"experience together "		
35	"walking together"		
36	"sharing with faith"	H (DEEPER LEVEL) *LINGXING* CARE	

37	help the understanding of life	36,37	
38	"Xinling lingxing care not much different"	A2 *XINLING & LINXING* RELATIONSHIP 38.	A2 NOT much different
39	"hoping patients to know the faith"	I INTENTION OF CHAPLAIN 39,40,41	
40	Faith is delivered accordingly	32,33,34,35,36,37	
41	Faith can address the need		
42	Listening here and now	J SKILL IN CARING 42,43,44,45,46	

43	Acknowledging the emotion		
44	Showing empathy		
45	Understanding the narrative in past		
46	Sharing experience of peace in faith		
47	“Clear” VS. Practice	K DILEMMA OF PRACTICE 47,48	
48	“Confused” VS. Patients’ need		
49	“Lingxing is related closer with faith”	A3 XINLING LINGXING RELATIONSHIP 49,50	A3 Different
50	“xinling is a broader term than faith”		
51	“xinling care is addressing the need”	G2 V: *XINLING* CARE ADDRESS THE NEED 51,72,84,85,90	
52	“we are for care and support”	L ROLE OF CHAPLAIN 51,52,53,54,32,33,34,35	
53	Giving choice	G3 A: *XINLING* CARE CHOICE 53,54	
54	Respecting choice		
55	Need to grief	M NEEDS OF PATIENT & RELATIVE IN PALLIATIVE CARE55,56,57,58,59,63	
56	Need of space		
57	Need to express ‘four says’		
58	Need of company		
59	Need to be guided		
60	“I co-operate with the healthcare as a whole team”	N RELATION BETWEEEN NURSE & CHAPLAIN 60	RNC1 co-operate
61	Concerning the worry	J SKILL IN CARING 42,43,44,45,46,61,62	
62	Releasing the emotion		
63	Concern need to be understood	O NEEDS OF PATIENT & RELATIVE IN PAEDIATRIC CARE 63,64,65	
64	Children’s need to be happy		
65	Worries need to be listened		
66	Quick in responding to physical need	P ROLE OF NURSE 66,70,72, 78, 82,83,84	RNC2 different resources
67	addressing “long term” need	L ROLE OF CHAPLAIN 67,68,69. 51,52,53,54. 70,72, 75,76,77,78. 83, 85,86,87,88,89,90	
68	Addressing “xinling feeling”		
69	Addressing self-understanding		
70	“company and walking together”	G2 V: *XINLING* CARE 70,72,83,85	RNC3 No difference in *xinling* care
71	“With CPT”	Q CPT 71	
72	Sparing time with patient in need	G2 V: *XINLING* CARE 72	
73	“I don’t know” the work of nurse	N RELATION BETWEEEN NURSE & CHAPLAIN 73,74,79,80	RNC4 confused
74	“I am not clear” the time they can spare with patient		

75	Reading bible	H *LINGXING* CARE 75,76,77,78	
76	Guidance in faith		
77	Providing baptism and other liturgy		
78	Praying with patient		
79	"I am not clear" nurse pray or not	N RELATION BETWEEEN NURSE & CHAPLAIN 79,80,81,73,74	RNC4 confused
80	"I don't know" nurse can pray or not		
81	"I know nurse sometimes pray"		
82	Focus in caring physical body	P ROLE OF NURSE 82, 83,84,85. 66,70,72,77	
83	Caring the emotion		
84	Referring to chaplain for xinling/lingxing care		
85	Giving the bible a/c to need		
86	"no special focus"	L ROLE OF CHAPLAIN 86,87,88,89 67,68,69,52,70,71,72, 75,76,77,78, 83, 85,90	RNC4 confused
87	"my focus of lingxing care is addressing the need"		
88	Pastoring healthcare professionals		
89	Emotional "back up" nurse		
90	Referring to nurse	G2 V: *XINLING* CARE 90	
91	Adapting hospital operation	R DIFFICULTIES OF CHAPLAIN R1 MINISTRY 91,92,93,94 R2 SELF 95,96,97,98. 107	
92	Experiencing stress together		
93	"I don't understand the HC professional"		
94	"still learning to establish a pastoral relationship"		
95	Solving own struggle		
96	"Calming myself"		
97	Xinling need to share and feel supported		
98	Lack of time to do reflection		
99	"I have to be healthy"	G1 B: *XINLING* CARE 99,100,102,	
100	"God's calling"	Q CPT EXPERIENCE "GOD'S CALLING & GUIDANCE">SPIRTUAL CARE	CPT and Experiencing God
101	Life experience as preparation		
102	God's guidance		
103	"God makes the way"		
104	Small group learning	S CPT HELPFUL ELEMENT 104,105,106	CPT and helpful element
105	Theological reflection		
106	Confirming pastoral identity		
107	"not good enough"	T GOD>CHANGE OF IDENTITY>CONFIDENCE 108,109,110,111>107>106	CPT and the identity
108	God waiting for me		
109	God's confirmation of the identity		
110	God's healing		
111	God works in me		
112	"depending on God"	U THE BEING OF CHAPLAIN 112,113,114,115. 107,109,110,111. 100,101.	
113	Work together with God		
114	"experience together with others"		
115	"responsive to the calling"		

Coding Table: SY

	Code	Category	Sub-Category
1	A platform for practice	A CPT EXPERIENCE 1,2,3,4,5,	A1 CPT & Relationship
2	Practicing caring and counselling		A1a Self: growth
3	"Reflection to enhance self-understanding"	6,7,8,9,10,11,12,13,14,15	3,6,7,8,10,18,54,68,71
4	"God calls"		A1b God:4,5,68
5	A wonderful preparation		
6	New perspective of self	B PERSONAL GROWTH 6,7,8	
7	Weak VS strong	3, 9, 10,11,	
8	Difficulty VS self-transcendence		A1c
9	Mutual acceptance	C TRUSTING GROUP RELATIONSHIP	Others:9,13,14,15,54,55,69,70
10	Enhance self-confidence	9,10,11,12,13,14,15	
11	"Understanding of others and self"	2,6,7,8	
12	Recognition of the chaplaincy role		
13	Sense of security		
14	Feel supported		
15	Encourage genuine expression		
16	"Enhance openness and self-understanding"	D IPR (INTERPERSONAL RELATION) 16,17,18	A2 CPT helpful elements
17	"Personal growth stepping stone"	15,14,13,11,6,3	A2a small group
18	"Stepping out from the comfort Zone"		A2b IPR
			A2c Individual Supervision
19	Private time	E Individual supervision 18,19	
20	Personal connection	F SPIRITUAL,XINLING CARE	SPIRITUAL CARE vs COUNSELLING
21	Personal touch	20,21,22,23,24,25	F1a SAME 20,22,25
22	Walk together	30,31,32,33	F1b DIFFERENT
23	Two equal subjects	34,35,36,38	21,23,24,
24	"Me and you walk through together"		26,27,28,29,55
25	A kind of empathetic understanding		SPIRITUAL CARE
			F2a SELF 26-29,47,55,69,60,64
26	"I have difficulties"	G AWARENESS OF SELF IN SC	
27	"I am helpless"	26,27,28,29	F2b OTHERS 30,31,32,33,20-25,69,57,58,59,61,63
28	"I am a human with needs"	24,23,22,21,20,48,49,50,52,54	
29	"I accept myself as I have limitation"		F2c GOD 39,40,41,48,69,50,52
30	Listening	H WALK TOGETHER 30,31,32,33	
31	Accompany	29,28,27,26,	
32	Acceptance	25,24,23	
33	Without judgement		
34	"my intention is to evangelize"	I DILEMMA OF PRACTICE	A3 CPT for Integrative Practice
35	"my ultimate purpose is to bless"	34,35,36,37,38,42	34-38
36	Establishing a deeper relationship	43,44,45,46,55,56,63,73	
37	"I don't want to hard sell"		
38	"Care" VS "Gospel"	J DISINTEGRATION 38,63	

39	Praying	F SPIRITUAL XINLING CARE 39,40,41	
40	Holy Spirit touching		
41	Holy Spirit participating		
42	"I am disintegrated within"	J DISINTEGRATION 42,43,44,45,46,	
43	"Gospel" VS "Daily Life"		
44	"Meaning making in faith" VS "Cannot understand"		
45	"Experience" VS "practice"		
46	"Faith" VS "Living out"		
47	A whole integrated self	F SPIRITUAL XINLING CARE 47,48,49,50,52,53	A4 CPT & Reflection 48-52,54,55,56,65 Reflection K1 Relationship 48,49,54,56,66 K2 Action 51 K3 Self 3,52,54,55,65
48	"Relationship with God"		
49	Refection through people relationship	Ka REFLECTION > HOLY SPIRIT >INTEGRATION 3,6,47,53,66	
50	"Reminder of the Holy Spirit"		
51	Action Reflection		
52	Holy Spirit working within me		
53	"Chaplaincy is beneficial to others and self"		
54	"Discerning self and other"		
55	"Skill" VS "Self"	J DISINTEGRATION 55, 56	
56	"Share to inspire" VS "Teach to preach"		
57	Responding here and now	F SPIRITUAL XINLING CARE 57,58,59,60,61	
58	Addressing the spiritual need		
59	Expressing empathetic understanding		
60	"Enhance self-understanding"		
61	A sense of being cared		
62	"I don't know how to put it neatly"	J DISINTEGRATION 62	
63	"Inspiring hope using the gospel"	F SPIRITUAL XINLING CARE 63,64	
64	Walking together with a true self		
65	"Reflection is to explore the treasure of life"	Kb REFLECTION> FAITH>SPECIAL SELF	
66	"Life is to live out the special self in Jesus"		
67	Life is meaning-making with faith		
68	"Understanding God and self"	A CPT EXPERIENCE	
69	"Understanding God and self can enhance caring"	F SPIRITUAL CARE 69	
70	"Enhance understanding of patient"	A CPT EXPERIENCE	
71	"Clarifies blind spot of self"		
72	"Individual supervision"	L NEED OF CHAPLAIN 72,73,122,138 Doing> Blocked>Wrong conception of self> Difficult service	
73	"Sharing" VS "Doing"		
74	"Blocked" VS "self-awareness"		
75	"*Lingxing* is one part of the four	M *XINLING LINGXING* RELATIONSHIP	

	dimension”	M1 DIFFERENCE: 75,76,78,96-101	
76	“*Xinling* is broader, not only one part”	M2 SAME: 77,81,82,83,84, 86,87,88,89,102	
77	“*Lingxing* connotes our *xinling* needs”		
78	“*Lingxing* seems to be broader”	M3 CONFUSED: 79,93	
79	“I am confused”		
80	“Religion is some beliefs”		
81	Being understood	N *LINXING* 81,82,83,84,85 97,98,99,101	*Lingxing* interchangeable with christianity
82	“Religion is not only set of beliefs”		
83	“It is life” connecting		
84	Togetherness		
85	“Need of individual can be different”		
86	“Need of company”	O *XINLING* 86,87,88,89, 96,100	*Lingxing* interchangeable with *xingling*
87	Worries need to be shared		
88	Need to be helped		
89	Universal need		
90	“Peace”	P BELIEFS OF PRACTICE 90,91 121,123,124,125,126,131	
91	Building relationship		
92	“Share” VS “Choice”	I DILEMMA OF PRACTICE	
93	“*Xinling* is not religious…no, seems that it is ”	M3 *XINLING LINGXING* RELATIONSHIP M3: 93,94,95	In relation to religion
94	“No difference…has differences I can’t tell”		
95	“I don’t know how to make it clear”		
96	“*Xinling* is physio-psycho-social spiritual”	M1 DIFFERENCE: 96,97,98,99,100,101	
97	“*Lingxing* is relationship with one God”		
98	“About meditation, bible, prayer”		
99	“*Lingxing* is religious”		
100	“*Xinling* is more holistic”		
101	“*Lingxing* from church is disintegrated”		
102	Health is holistic	M2 SAME 102	
103	Self-understanding	N *LINXING* 103,104,105 90 122,123,124,125 Self-understanding>God> Freedom>Others	*LINXING* O1 Self,103,105 O2 God 104,97 O3 Doing 98
104	Authentic relationship with God		
105	Connecting with self		
106	“Accepting” the uniqueness		
107	Free to connect		
108	Need of belongingness	O *LINXING* 108,109	
109	Need to connect with the spirit		
110	“Love”	Q VALUE OF PRACTICE 110,111,102	
111	“Respect”		

112	"keep company"	F SPIRITUAL XINLING CARE 112-120 110,111 121-125	SPIRITUAL CARE F1 Skill 112,113,114 57,58,59,61 F2Task 115,116,117,118 119
113	Empathetic understanding		
114	"Listening"		
115	"Seeing the self, finding the self"		
116	"finding the meaning"		
117	"Relieving"		
118	"Hope inspiring"		
119	Encouraging to accept the reality		
120	Being available		
121	"Not human's work but God's works"	R FACTORS AFFECTING PRACTICE 121,122,123,124,125,126	
122	Need of prayer		
123	"Personal relationship with God"		
124	"Understanding of God"		
125	"Life experience"		
126	"My spirituality is utmost important"		
127	"Stepping into one's shoes"	F SPIRITUAL CARE 127,128,129,130,131,132	
128	Interacting personal relationship		
129	"Patients are helping me "		
130	Widening my perspectives		
131	"Everyone needs the care"		
132	"Continue to connect"		
133	Supervisor as spiritual guidance	R FACTORS AFFECTING PRACTICE 133,134	Healthy *xinling*> healthy practice
134	Healthy *xinling*		
135	"Sleeping"	S HEALTH OF THE BEING 135,136,137,138 133, 134,126,123,122 103-106	
136	"Jogging"		
137	"Family gathering empower"		
138	"Connecting with my family"		
139	Sense of belonging	T HOME 139,140,141,142,143	Home > Healthy *xinling*
140	Place of security		
141	"Resting peace"		
142	"Strength"		
143	"To care and be cared"		
144	Interacting relationship in church	Q HEALTH OF THE BEING	
145	Conflicting spirituality perspectives	U CHRISTIAN SPIRITUALITY	
146	"Help" VS "Hinder"		
147	"Used to" VS " Don't know"		
148	"Pre-supposition" VS "Accepting"		

Coding Table: MF

	Code	Theme	Sub-theme
1	"Related to life"	A CPT EXPERIENCE	A CPT Exp. Aa Togetherness Aa1 peer
2	"Sharing life stories"	A1 Sense of togetherness in CPT 2,3,4, 17,18,52,54,57	
3	"Acceptance"		
4	"Encouragement"		
5	Abuse in family	B HURT IN LIFE 5,6,7,49	
6	"Being rejected in church"		
7	"Shock"		
8	"Woman has no say in family"	C BELIEFS ABOUT SELF 8,9,10,11,56	
9	Woman is to hold the family as a unit		
10	"Tolerate"		
11	"I know nothing"		
12	Need to be understood	D XINLING NEED 12,13,14,15,16 3,4 XINLING NEED ADDRESSED> GOD> LOVE	Ab Cared & Care
13	Need to be listened		
14	"Prayer"		
15	Need to share		
16	God's presence		
17	"Continuing love"		
18	"Walk together"		
19	"Xinling need is universal"	E XINLING CARE 19,20,21,22 17,18	E XINLING CARE Eb1Belief: God's servant Eb2Value: walk together Eb3Attitude: love
20	"Sense of being cared"		
21	"God's servant to care"	E XINLING CARE Belief 21 XINLING CARE PROCESS RELATIONSHIP 17,18,20,22,23 > EXPLORATION24,25 > DEEPER> 26,27,> PRAYER > SELF PRAYING	
22	"Care is here and now"		
23	"Building relationship"		
24	Exploring life experiences		
25	Share according to interest		
26	"Relating the self to Christian beliefs"		
27	"Going deeper to explore"		
28	"Pray for patients' need"		
29	Praying for self so to experience		
30	"Step by step"		
31	"Lingxing is not faith"	F LINXING 31,32,33,34,35,36,37,38 Confused relationship with faith Confused relationship with xinling Fa with faith 40-43 Fb not related with faith 39	F LINXING Fa with faith Fb Not faith Da NOT related to faith
32	"Concern"		
33	"Worry"		
34	"Feeling"		
35	"Hope"		
36	"Is not related to faith"		
37	"Is Need here and now"		
38	"Higher level of lingxing relates more to faith"		
39	"Xinling needs are not related to faith"	D XINLING NEED 39,40	
40	Need to be forgiven by God		

41	Need to be accepted by God	D XINLING NEED 41,42,43 3,4,12-16 Eb XINLING CARE PROCESS 44,45,46,47,48 LISTEN > NEED >ACCEPTANCE > LOVE >CHANGE	Db with faith 40,41,42,43
42	Need to "Reflect and confess"		
43	Need of admitting sin		
44	Accepting God's unconditional love		
45	"Belief in God"		
46	"Regret and return"		
47	"Not judge"		
48	"Not giving advice"		
49	Anger VS. Silence	B HURT IN LIFE 5-7,49,50,51	Ac1 BELIEFS OF SELF
50	"Low self-image"		
51	Separated family is shame		
52	"Withdraw" VS. "Acceptance"	A CPT EXPERIENCE 52,53,54 A1 USEFUL ELEMENTS 52-54, 57,79-80	
53	"Express myself thru' CPT work"		
54	"Treating me gracefully"		
55	"Shame" VS. "Abused"	B HURT IN LIFE 5-7,49-51,55	
56	"Destined" VS. "I can do it"	C BELIEFS ABOUT SELF 8- 11,49,50,51,56	
57	Church "rejection" VS. Supervisor "encouragement"	A CPT EXPERIENCE52,53,54,57	
58	"God equips me thru' hurt"	G RELATIONSHIP WITH GOD	CONFLICT IN CHURCH> HURT > ⬇INTIMACY WITH GOD
59	"Introvert" VS. Smiling Face		
60	"Preach" VS. "Life"	H CONFLICT IN CHURCH 60,61,62 57,55,6,7	
61	"Care" VS "Judgement"		
62	"Listen" VS "Loss"		
63	"God is here" VS. "Hurt"	G RELATIONSHIP WITH GOD 63	
64	"I don't know my need"	A CPT EXPERIENCE 64,65,66 A3 SELF DISCOVERY	Ac2 SELF DISCOVERY HURT > SELF >CPT > SELF-DISCOVERY > TRANSFORMATION
65	"Secured to express"		
66	"Willing to open"		
67	"Self-acceptance"	A4 TRANSFORMATION OF SELF 67,68,69,70,71,72	
68	"Face the problem"		
69	"Assessment" VS. Overwhelm other		
70	"Wider perspective"		
71	"I have resources"		
72	Past experience VS. Transformed self		
73	"Crying together"	A CPT EXPERIENCE 73,74,75,76 77,78,93 A1 SENSE OF TOGETHERNESS	Relationship>self *xinling> xinling* care Aa TOGETHER Aa1 Peer Aa2 Self
74	"I have to risk myself"		
75	"Willing to walk together"		
76	Mutual openness		
77	"Learning through observation"		
78	"Interactive" relationship		
79	"Confidentiality"	Aa USEFUL ELEMENTS 79,80	
80	"Supervisory Guide"		
81	"Love"	A5 SUPERVISOR 81	

82	“Continuing care”	A5 SUPERVISOR 82,83,84,85,93	Aa3 supervisor Supervisory relationship > self > care God> Self > care E XINLING CARE Ea GOD Eb SELF
83	Flexible		
84	Understand my need		
85	“Without God, my care is limited”		
86	Experiencing God’s love	G RELATIONSHIP WITH GOD 86,87,88	
87	“Grace on me”		
88	“Listen humbly to Words”	E XINLING CARE Ea God 88,89,90,91 Eb self 88,90,95,96	
89	“God prepares the coincidence”		
90	“God works within my intuition”		
91	“No God, no life, no care”		
92	“Reflection journal”	A2 USEFUL ELEMENTS 92,93,94	
93	Interacting “feedback”		
94	Didactic		
95	Understanding self and others	E XINLING CARE 89-91, 95,96,97,98,99,100,101 Ec Healthcare staff 98,100,101	Ec HC staff Care> Relationship> self> Satisfaction
96	Adjusting the same pace		
97	“God works together”		
98	“Ward staffs see, patients know”		
99	“not working in vain”		
100	Self-initiated VS. Others’ notice		
101	Recognition from staff		
102	“Lingxing associates with faith”	F LINGXING Fa2 associate with faith 102, 103,104,105,106,38	LINGXING in relation to faith
103	“From church understanding”		
104	“about gospel preaching”		
105	“Depth deep in the heart”		
106	“A xinling gap needed to be filled by God”		
107	“ physio-psycho-social-spiritual”	E XINLING 107,108,109 Ea with care	
108	“Xinling support is not only faith”		
109	“Xinling is holistic”		
110	“Deepest prt of spiritual”	F LINGXING	
111	“step by step, level by level”	E XINLING CARE114,	
112	“patients’ need centered”	Eb1 XINLING CARE BELIEF 112,113,21 Ed XINLING CARE PROCESS Ed1 Upper 115,116,117 Ed2 Deeper 118, 119,120,121,122,123-124, 129-130 Ed3 Deepest 122	Eb Self Eb1 Belief Eb2 Value Eb Process Introduction >relationship >upper level >assessment >deeper level >deepest level
113	“patient does not belong to us”		
114	“understanding the narrative		
115	Emotional upset		
116	Family problem		
117	“Unfinished business”		
118	Deeper relationship as base		
119	“Deeper level of worry”		
120	“Pray if appropriate”		
121	“Slowly and gradually”		
122	“Introducing our faith”		
123	“Struggles”		

124	“misunderstanding our faith”	Eb2 xinling care value 125 Ed1 Introduction 126,127,128	Assessment Index for deeper level care: 1 Physio-psycho social appropriateness 2 Relationship In between 3 Acceptance of blessing prayer
125	Respecting choice		
126	“Christianity chaplaincy”		
127	“For care”		
128	“Not for hard sell”		
129	Sharing personal experience	Ed3 DEEPER LEVEL 129, 130	
130	Telling Bible story		
131	“Bringing up the needs of God”	Ed4 DEEPEST LEVEL 131,132	
132	God VS. No God		
133	Assessment VS. Delay	E XINLING CARE 133,134-138 114	
134	Genuine presence		
135	Accompany		
136	“irrespective the time together”		
137	“Connecting”		
138	Praying for the need		
139	“ deepest needs to be satisfied”	I SPIRITUAL Ia related with care XINLING 139,140,141-146 148	Spiritual Ia Interchangably with Xinling
140	“Perspectives”		
141	“Expectation”		
142	“Own resource”		
143	“Forgiveness”		
144	“Individually different”		
145	“May/not related to Christian faith”		
146	“Xinling in hospital more”		
147	“Spiritual is lingxing needs”	Ib Lingxing 147,148-152	Ib Lingxing
148	“Peace”		
149	“Including religion and others”		
150	“Unfinished business”		
151	“Deeper than xinling the superficial level dimensions”		
152	Relationship > Exploration		
153	“Two parts”	J Xinling Lingxing Relationship 153,154,155	
154	Xinling on “top” level		
155	Lingxing “down” a bit		
156	“Reconnect with God”	E XINLING CARE 156,157,158,159	Continuing cared >God> TOGETHER > CHANGE > SATISFACTION
157	Dealing with fear		
158	“True encounter”		
159	Change in life		
160	“God brings me to ward”		
161	“I work for God”	K RESOURCE OF MINISTRY161,162 160, 81,82	
162	“God leads me”		
163	“Enjoy experiencing together”	L SATISFACTION FROM CARE 163	
164	Family’s need VS. Pt’s wish	M DILEMMA OF PRACTICEE	

165	Request VS. Rejection	164, 165-168	
166	Rejection VS. Continuing care		
167	Fear VS. “Get closed”		
168	No Response VS. treat equally		
169	“Continuing love”	Eb3 XINLING CARE ATTITUDE 169	
170	“professional”	N NURSE CAREGIVER 170,171-2	Nurse in relation to Chaplain
171	“Treat and listen		
172	“Being depended by patient”		
173	“Flexible”	O CHAPLAIN CAREGIVER 173, 174-5	Chaplain in relation to Nurse
174	“Chance”		
175	“Focused listening”		
176	“Similar if Christian nurse”	P RELATIONSHIP NURSE & CHAPLAIN Pa similar Pa1 176,177,179 Pb difference, 170,172,178,180-4, 191,195	Relationship between both
177	“Sharing Lingxing, faith topics”		
178	“Overnight” VS. “Office hour”		
179	“Experienced nurse can listen”		
180	“relatives” VS. “whole picture		
181	“Guidance”	O CHAPLAIN CAREGIVER 181,182-4	Chaplain in relation to Nurse
182	“Walk Deeper”		
183	“More time to patient”		
184	“Caring relatives”		
185	“Faith cannot be left out”	Q IDENTITY OF CHAPLAIN 185,186	
186	“Care with God’s love”		
187	“Peace from God”	Eb2 XINLING CARE VALUE 187	
188	Restoration relationship	R TASK OF CHAPLAIN 188,189-192	
189	Experiencing God’s love		
190	“Arouse the need of God”		
191	“Preaching Gospel if appro”		
192	Gospel is “ultimate” purpose		
193	“Starting” VS. “Last moment”	M DILEMMA OF PRACTICE 193,194	
194	“ Caring” VS.“Gospel”		
195	“Ultimate” purpose is “lingxing is faith”	E XINLING CARE 195	
196	“Self-understanding”	S ENHANCEMENT FOR PRACTICE 196,197-200	
197	“Group” for blind spot		
198	“Continuing education”		
199	Time for reflection		
200	“Reminder”		
201	Experiencing God	A CPT EXPERIENCE A1 USEFUL ELEMENTS OF CPT	
202	Theological Reflection		
203	“God’s grace”	K RESOURCE OF MINISTRY	
204	“Strength from God”		
205	“God is in control”		
206	“Guilt” VS “Limitation”	M DILEMMA OF PRACTICE	
207	Need of others VS N of Self		

Coding Table: PC

	Code	Theme	Sub-theme
1	"Communicating more"	A CPT EXPERIENCE 1,2-6	A Aa Increased understanding
2	"Understanding deeper needs"		
3	"Referrals" VS. "Do a bit more"		
4	"Pray together"		
5	"Comforting"		
6	"Accompany"		
7	"Helpless" VS. "Listening helps"	Ab CHANGE AFTER CPT 7-10 1-6	Ab Change after CPT
8	"Not doing but company"		
9	Problem-solving VS. care by listening		
10	"Leave" and refer VS. "Hold more"		
11	"Not enough" training	B BELIEF OF CHRISTIAN NURSE 11,12,13,14-18 3,4,5,6 UNIVERSAL NEED 16 > CARE IN LOVE WITH GOD'S LOVE14,15 > ACCEPTANCE 17,18	
12	"Christian nurse should care more"		
13	"Doing more"		
14	"Facilitating" more God's love		
15	"Sharing God's love"		
16	"Love is universal"		
17	Accepting the love with faith		
18	Respecting choice		
19	"Skill knowledge" VS. "Accompany"	C DIFFERENCES BETWEEN NURSING CAREGIVING TRAINING & CPT	
20	Not religious VS. Christianity		
21	"physio-psycho-social-spiritual" VS. "*xinling* emphasis"		
22	"Deep Down Feelings"	D *XINLING* CARE 22-25	
23	Inner side belief		
24	"Not easily touched"		
25	"Need to be cared"		
26	"Meditation"	E *LINGXING* 26,27,28	
27	"Cosmic natural therapy"		
28	Christianity and other beliefs		
29	"Interpersonal love"	F SPIRITUAL NEED	
30	Connecting		
31	"God-human relationship"		
32	"Different individual need"		
33	Need of God dependent		
34	"Awareness" of God		
35	Connecting with self		
36	"Self-understanding"	Ac CPT EXPERIENCE PERSONAL GROWTH 36-39	Ac Personal growth
37	"Inter-personally related"		
38	"Not judging"		
39	"More understanding"		

40	Meaning of walking together	Ad CPT EXPERIENCE SELF DISCOVERY 40,41,42	Self-under'g> Humble> >God's mercy > Compassion >Blessing
41	"All are sinners"		
42	Cared and caregiver are "equal"		
43	"Compassion"		
44	"God's mercy"	G VALUE OF CAREGIVING 43,44,45	
45	"Blessing in believing God"		
46	"I may not evangelize"	H ROLE OF CHRISTIAN NURSE 46-49	
47	"Facilitate" by "love"		
48	"Facilitate" by caring "environment"		
49	"Facilitate by "Referring"		
50	"Liaising with" chaplain	G VALUE 50, 51,69,104	
51	"Doing more" by "liaising with"		
52	"Concentrate in visiting process"	Ae CPT EXPERIENCE VISITATION	
53	"bringing before God"		
54	"Prayer"		
55	"Providing time to talk"		
56	Verbatim	Af USEFUL ELEMENTS	
57	"A process"	D *XINLING* CARE 57,58 53,54,55,59	
58	"Care by listening"		
59	"Not problem-solving		
60	Church with religion	E *LINGXING*	
61	Used in hospital	I *XINLING* 61-66, 29-35	
62	"Individually different"		
63	"Needs may not be faith related"		
64	About "Worries"		
65	"Beliefs"		
66	Related to "different religions"		
67	"Naturally sharing about God"	D *XINLING* CARE 67-69	
68	Not "hard sell"		
69	Holism		
70	"Sharing naturally in caring"	J NURSE CAREGIVING	
71	Doing good physical care		
72	Leading to seek faith easily		
73	Meaning of life	K *XINLING* NEED 73-80	
74	After death		
75	Seeking		
76	Fear		
77	Family love		
78	Need of security		
79	"Amplifying in sickness"		
80	Need of knowing a God or not		

81	Nursing easy to express	D *XINLING* CARE 81-92 Da PROCESS OF CARE	Db Attitude: Love 16 Respecting 85
82	“Decreasing the physical symptom”		
83	“Explaining to address fear of unknown”		
84	Addressing the physical limitation		
85	Respecting their dignity		
86	Nursing care is comforting relatives		
87	“Settling down”		
88	Comfortable enough to plan		
89	Preparing for future		
90	Referring chaplaincy		
91	“Teamwork”		
92	“Sharing deeper if time allows”		
93	“Nurse suitable to share deeper”	B BELIEF OF CHRISTIAN NUR	
94	“Lacking time to share deeper”	L LIMITATION	
95	Healthcare person VS. religious person	M NURSE CHAPLAIN RELATIONSHIP NURSE 95,96,97 > REFERRAL 98,99 > CHAPLAIN’S ROLE 100,101,102 > CONTINUOUING CARE 103	
96	Comfort naturally VS. “time to connect”		
97	Holistic care VS. faith focused		
98	“Liaising with”		
99	“Walking together to Introduce”		
100	“Expecting them know how to connect”		
101	Gospel VS. Holism		
102	Chaplaincy Training > Addressing needs		
103	Continuing care		
104	“Addressing needs”	D XINLING CARE 104,105,106	
105	“letting patients to tell the concern”		
106	Referring to different resource		
107	“Pray if patient wants”	B BELIEF OF CHRISTIAN NUR 91, 107-113,124	Ba LOVING CARE Bb PRAYER > HANDOVER Bc CHAPLAIN & GOD > CONNECTING
108	“Pray to hand over”		
109	“Connecting God”		
110	“Pray means help”		
111	“God express through our hands”		
112	Showing God’s love through our love		
113	God works through us		
114	Physical care is ”part”	D *XINLING* CARE 114	
115	“Heart” to help	N ENHANCEMENT FOR PRACTICE 115-121,122	
116	Willing to understand deeper		
117	“Walking an extra mile”		
118	“Listening to a whole person”		
119	“EXPERIENCE”		
120	“Attitude”		
121	“Communicating skill”		
122	“Practicing listening”		

123	“Doing basic nursing care well”	D *XINLING* CARE 122	
124	“Good caring role model”	N ENHANCEMENT FOR PRACTICE 124-128, 132	
125	Appreciating		
126	Putting the strengths together		
127	caring one another in the “team”		
128	“putting down oneself”		
129	Genuine presence	A CPT EXPERIENCE Aa INCREASED UNDERSTAND *XINLING* CARE	Increased understanding in CPT > less fear > growth > Spiritual health > Walk together
130	“Same pacing”		
131	Providing safety haven		
132	CPT can facilitate caring	N ENHANCEMENT	
133	“Dare not”	O NEEDS OF NURSE	
134	“Fear of not knowing how to respond”		
135	“Fearful of asking”		
136	“Christian nurse should take CPT”		
137	Understanding > Decreased fear		
138	Solving VS. “Facilitating” resource		
139	Self- understanding	P PERSONAL GROWTH	
140	“Facing the hurt”		
141	“Wider perspectives” seeing the past		
142	Others have VS. I have the weakness		
143	“I have needs”	Ad SELF DISCOVERY	
144	“Profession” VS. “walk together”	Aa INCREASED UNDERSTAND	
145	Reflection	Af USEFUL ELEMENTS	
146	Reading books		
147	“Debriefing” verbatim		
148	“Individual yearning in heart”	E *LINGXING*	
149	Feeling		
150	Perspectives about life		
151	About beliefs		
152	About faith		
153	May not be described by words		
154	“Similar with *lingxing* and faith”	I *XINLING*	

Coding Table: KM

	Code	Category	Sub-Category
1	"Relationship with self"	A LINGXING 1-27	
2	"Relationship with others"		
3	"Relationship with the world"		
4	"Relationship in relation with God"		
5	"About meaning of life"		
6	"Direction of life"		
7	"Holistic"		
8	"Hope"		
9	"Transcendence"		
10	"Naturally manifest in daily living life"		
11	Affected by environment		
12	Affecting the experience		
13	"Freedom inside"		
14	"United with God"		
15	"Selfless"		
16	"beneficial to others"		
17	"Union"		
18	"Original"		
19	"About the sacredness of human"		
20	Different within Christianity		
21	About "prayer, bible, church going"	LINGXING understanding in general church	
22	"Behavioral"		
23	"Relationship with God"		LINGXING About Relationship Experiences
24	"Not clear" about the relationships		
25	"Relationships of self, world, God"		
26	"Instinct"	LINGXING	
27	"Human nature"		
28	Personal "experience"	B RELATIONSHIP WITH GOD 28-35	
29	Receiving from God		
30	Telling God		
31	Understanding		
32	"Walking same direction"		
33	Communication		
34	"Connection"		
35	"Complicated"		

36	Not necessarily with religions	A LINGXING A1 In relation to religion 36-42	LINXING Broader than religion
37	Beliefs		
38	“Shàngtiān Tiāndì”		
39	Life		
40	“Not from other’s input”		
41	vague		
42	“Self-transcendence”		
43	“Individually different understandings”	A1 In relation to religion 43	
44	“Rule, formal, institutional”	C RELIGION 43-46	Lingxing and religion relationship
45	“Lingxing and religion are different”		
46	“Narrower, related to organization”		
47	Miracle		
48	“Used together with care”	D XINLING 48-58	XINLING Different From LINGXING
49	“Chaplaincy” term		
50	Emotion and feeling		
51	“Love”		
52	“Should be different from Lingxing”		
53	“Accompany”		
54	“Not relating to Jesus as the example”	D1 XINLING IN CPT 53-56	
55	“Don’t know”		
56	“Not understanding deep enough”		
57	“Case” studying		
58	“Terms individually different”	D2 XINLING LINGXING RELATIONSHIP 51,57,58	Confusion
59	“Lingxing is more high-sounding”		
60	“Different understandings within Christianity”		
61	“Incoherent”		
62	Theory VS. Practice		
63	“Varied strangely”		
64	“Different usages”		
65	“Various usages of the same term with the same person”		
66	“Same but use differently”		
67	“Difficult to distinguish in details”		
68	“Busy”	E Difficulties in Practice	
69	“Too many duties to care”		
70	Nursing care VS. nursing spiritual care		

71	“Responding” to needs	F CAREGIVING	
72	Feeling of comfort		
73	Bedside talking		
74	“Smiling”		
75	Is “psychological care”	G SPIRITUAL NURSING CARE 75-89	Confused Understanding In spiritual nursing care
76	“May be talking is spiritual care”		
77	Is “psychosocial care”		
78	“Sparing enough time with”		
79	“But…but…you’ve done but not aware”		
80	Only left with “Providing privacy”		
81	“Nurses don’t understand”		
82	Natural caring VS. Emphasizing spiritual care	G SPIRITUAL NURSING CARE 75-89	
83	Only left with “drawing curtains”		
84	“Connecting” the transcendence	H SPIRITUAL CARE ELEMENT 84-86	
85	“Singing gospel songs”		
86	“Praying for”		
87	“sharing about life meaning”	H SPIRITUAL CARE ELEMENT 87-89	
88	“Giving water to drink”		
89	“Very difficult and mystical to describe”	G SPIRITUAL NURSING CARE 90-9	
90	“Try my best to respond”		
91	“Clearer to say holistic care than SC”		
92	“Not that troubling”		
93	“Different people have different understanding”		
94	“Very very difficult to communicate”		
95	“Not many people really show concern”	E DIFFICULTIES IN PRACTICE 95-97 93,94, 103,101,103,105	
96	Assessment VS. religious faith		
97	“No one cares unless one really wants to”		
98	Emotional “counselling”	I CHAPLAINCY XINLING CARE	
99	When “clinical psychology not available”		

100	"Not many nurses facilitate" spiritual caring resource	G SPIRITUAL NURSING CARE 100-110	
101	Physio-psycho-social-spiritual VS. Spirit		
102	Spiritual emphasis only in church		
103	"Highlight" VS. "Natural"		
104	Helping "finish the unfinished business"		
105	"Formally" VS. Naturally as friendship		
106	About "person to person connection"		
107	Emphasis more on "chronic" setting		
108	Life is connected		
109	"Humanistic"		
110	"Not permitted" VS. Natural connect		
111	Accepting	G SPIRITUAL NURSING CARE 111-118 1 Process Experiencing together>connection> caring > moved	CARED > CARING
112	Understanding		
113	Accompany		
114	Care the cares		
115	Express the concern		
116	Cared> Caring		
117	Connect to self > connecting others		
118	"Not doing much" VS. appreciate		
119	About connecting with God	J SPIRITUALITY OF CAREGIVER 119-123 Experience > difficult to express > Natural VS. formal > frustrated	CONNECTING SELF, WORLD & GOD > CONNECTING OTHERS
120	Connecting world with God		
121	Needs to aware		
122	Needs to be nurture		
123	Starting with questioning continuously		
124	"Non-stop seeking"		
125	Connecting bible and the reality		
126	"Annoyed"		
127	"Difficult to express formally"	J SPIRITUALITY OF CAREGIVER	
128	About experiences		
129	"Frustrated"		

130	"Care" VS. "Not knowing"	G SPIRITUAL NURSING CARE	ACCEPTED>
131	Natural "relationship" VS. "Don't know"	2 Beliefs: Connect self > connect other Listened> listening Accepted >accepting Cared >caring	ACCEPTANCE
132	Caregiver being accpeted > Acceptance		
133	Touching		
134	Help VS. "how"		LISTENED> LISTENING
135	"Others do not know how"		
136	Listened > listening		
137	" Being understood is important"		
138	People cannot communicate	K FRUSTRATION OF CHRISTIAN NURSE	
139	Sharing about God is not Nursing		
140	Faith > Belief about life and death		
141	"Church teaching does not help"		
142	Church VS. Hospital culture		
143	Gospel VS. patients' need		
144	"Do more to help"		
145	Addressing the needs of patients	G SPIRITUAL N C	
146	May be needs of God	L NEEDS OF PATIENT 146-148	
147	Needs of company		
148	Love		
149	Support including from God		
150	Closest to patients	K FRUSTRATION OF C N Close>understand>help	Increased Understanding > help to serve
151	"There is something I can do to help more"		
152	About "xinling caring"	M CPT UNDERSTANDING	Increased understanding >help to serve
153	Bring up faith, hope and love		
154	"Learn to serve"	Beliefs: blessed > blessing	
155	Blessing from God > send blessing		
156	Sharing about God's love	G SPIRITUAL NURSING CARE	
	Faith > Connecting world and God		
157	"State" of being	N AFFECTING FACTORS OF SPIRTUAL NURSING CARE Relationship > Emotion > no awareness > no care	
158	Time and space		
159	Relationship with God, others and world		
160	"No peace"> no "space to aware"		

161	“Emotional psychological care”	O NON CHTISTIAN SPIRITUAL NURSING CARE 161-5	
162	“Company”		
163	“Talking”		
164	“Hugging”		
165	Comforting		
166	Stop pts crying Vs. Crying to release	E DIFFICULTIES IN PRACTICE	
167	“Depending the understanding of xinling care”	N AFFECTING FACTORS OF SNC	
168	Different church teaching about love	E DIFFICULTIES IN PRACTICE	Differences with Christian nursing care
169	Understanding about right		
170	Meaning of a good Christian		
171	Doing their job VS. Caring the cares		
172	Fulfilling responsibility VS. Caring better		
173	Presenting life story	P CPT EXPERIENCE 175,176 Group 173,174,177,178 179,181, Supervisory relationship 180,182,183,184	
174	Theory VS. Practice		
175	Process to understand the self		
176	“Widen my perspectives”		
177	Faith VS. Life		
178	“Miracle” VS. Reality		
179	“Same faith” VS. Varieties		
180	My problem VS. Other’s problem		
181	“Complicated” personal dynamics		
182	Choice to listen		
183	Increased self-understanding		
184	Distinction of the self and others		
185	Chaplaincy uniform is “representing”	Q CAREGIVER AS NURSE AND AS CHAPLAIN	
186	Religious person “link” easier		
187	“Linking” by prayer		
188	“linking” by “Jesus loves you”		
189	Nursing VS. “linking”		
190	“Complaint” if talking about God	Q CAREGIVER AS NURSE AND AS CHAPLAIN	
191	“Nurse can more easily approach”		
192	“No need to link with God immediately”	G NURSING SPIRITUAL CARE	
193	“I don’t know”		

194	“Reading”	P CPT EXPERIENCE Visitation 195,196,197,198	
195	Thin theology background > reflection difficult		
196	“Experiencing Holy Spirit in visitation”		
197	“Experience in among”		
198	Understanding God more		
199	“In touch with the Holy Spirit”		
200	“Relating” with different people	P CPT EXPERIENCE 201-202 Group 199-200,212 Knowledge 203-4, 209	
201	“Learning from others”		
202	Church reality		
203	Religious person limitation		
204	Caregiving direction		
205	Caregiving theory		
206	“Relating others”	P CPT EXPERIENCE Personal Growth 206-8 Church 210-211	
207	“Understanding the self”		
208	“Daily living in the world”		
209	“Understanding counselling more”		
210	Different understanding about Church		
211	“Christian elders are different”		
212	Chaplaincy volunteer service		

Coding Table: SC

	Code	Category	Sub-Category
1	Nursing work VS. nursing care	A DIFFICULTY IN NURSING PRACTICE,1-2	
2	“No space for caring”		
3	“Nursing work and xinling care”	B INTENTION OF NURSE CARGIVING 3-4	
4	“Praying to care a/c the needs”		
5	Continuing education	C PRESSURE OF NURSE 5-10 Ca PRESSURE OF CHRISTIAN NURSE 11,12	C Pressure Ca Pressure of Christian Nurse
6	“Physical” need		
7	Change in “role”		
8	Seeking for future direction		
9	Seeking for God’s will		
10	Need of the family		
11	Learning more		
12	Serving more		
13	“Understanding God more through nursing”	B INTENTION OF NURSE CAREGIVING	
14	Conflict in church	D CONFUSION IN CHRISTIANITY 14-17	
15	“Complicated”		
16	“Different perspectives”		
17	Different kinds of Christian		
18	“Co-operating with chaplaincy”	E CHRISTIAN NURSE CAREGIVING 17-28 32 Ea INTENTION 29	Christian Nurse 1) Intention 2) Nursing caregiving 3) Pressure
19	Non-stop volunteer service		
20	Caring patient’s need		
21	Caring relative		
22	“Evangelize”		
23	“Playing gospel song”		
24	“Talking”		
25	“Praying”		
26	“Caring in night shift”		
27	“Inviting for gathering”		
28	“God works through my caring”		
29	“Hoping pts. get to know God”		
30	“N training is God’s preparation”	F NURSING AS A CALLING 30-40	Calling 1)Nurse Training 2)Caring patient
31	Passion in the hospital		
32	God’s leading to care		
33	“Amazing”		
34	“Simple and natural”		
35	Caring colleague	F NURSING AS CALLING 35-39 Calling > Caring > Growth> Willing	Calling 3)Caring colleague
36	Mentoring junior		
37	Being cared > Caring		
38	Bible studying		
39	Caring > growth		

40	“Willing to do”		
41	Mal-practiced nursing care	C PRESSURE OF NURSE	
42	“I don’t know how to express”	Ca Practice 43,41	
43	“Busy” VS “Proper”	>Anger> don’t know	
44	Follower VS “supervisor”	42,46	
45	Capability VS role		
46	Inter-personal relationship	Cb Relationship >	
47	Conflict	conflict > Fear> hard	
48	“Anger”		
49	“Fear” of disharmony		
50	“Difficult to comment”		
51	"I was the problem” VS the problem		
52	“Evangelize clearly”	G CPT UNDERSTANDING	
53	“Sharing gospel wholly”	52-62	
54	“Learning caring”		
55	“Visiting effectively”		
56	“Letting patient to talk”		
57	“Learning to respond”		
58	“Self-understanding”		
59	“Dealing my problem in growth”		
60	“Listener”		
61	“The way to preach gospel”		
62	“Letting patient to know Jesus”		
63	“Sharing according to the needs”	H CPT EXPERIENCE	
64	“Heart”	I NURSE CAREGIVING	
65	“Holistic nursing care”		
66	“Dying without regret”		
67	“Saying goodbye”		
68	“Happy family relationship”		
69	“Singing”	E CHRISTIAN NURSE	
70	“God is among me and the cared”	CAREGIVING	

71	Caring patients in different ways	I NURSE CAREGIVING	
72	“Space” for caring		
73	“recognized” by colleague		
74	Chance to provide xinling care		
75	Trusting relationship	H CPT EXPERIENCE Nurse> Caring naturally> Accepting > more willing	CPT Ha Nurse and xinling care
76	Sharing their family		
77	Sharing personal growth issue		
78	Accepting me		
79	Caring “naturally”		
80	More willing		
81	“Used to my nursing role”		
82	“Focused”	J CHAPLAINCY CARE 82-84	
83	Flexible time		
84	Responding to patients’ need		
85	Addressing physio-psycho. needs	K XINLING CARE 85-89	
86	“Worries”		
87	“Deeper concern”		
88	“Listening to worries”		
89	“Free to express”		
90	Faith	L BELIEF AS A CHRISTIAN 90-91	
91	“Putting down one-self”		
92	“Present as a whole person”	H CPT EXPERIENCE Xinling care 92-97	Hb xinling care Within CPT
93	“Accompany”		
94	Caring the care		
95	“Not evangelize”		
96	“Not necessarily to talk”		
97	“Communicating skill”		
98	Understanding of my family	H CPT EXPERIENCE 98-102	Hc Personal growth
99	More perspectives of self		
100	Facing the hurt in growth		
101	Family communicate pattern		
102	Family relationship		
103	“I can trust”	H CPT EXPERIENCE 104 Hd CPT GROUP 103, 105, 106	Hd CPT group
104	“Understanding God more”		
105	“God’s servant” as supervisor		
106	Increased awareness		

107	“I can open and share”	Hd CPT GROUP 107-9	
108	“Learning to trust”		
109	“Releasing naturally”		
110	“Medication”	K XINGLING CARE Ia PROCESS OF XINLING CARE	
111	Comforter		
112	Pray		
113	Talk on faith naturally		
114	“Understanding deeper”		
115	Massage		
116	“Refer”		CPT experience Xingling care Self Others Family Wall > hurt > self in cpt > breakthrough
117	Communicate with social worker		
118	“Caring their needs”		
119	Establishing “trust”		
120	“Let them share the worries”		
121	“Compassion”	H CPT EXPERIENCE He PERSONAL GROWTH 123,124,127,129,130 Care: 125,126,128	
122	“Family”		
123	“Breakthrough” relationship		
124	Being able to “express myself”		
125	“Listening the narrative”		
126	“Doing life reflection”		
127	Understanding family relationship		
128	Life		
129	Growing background		
130	Everyone has blind spot		
131	“Helping by listening”		
132	Don’t know”	M HURT IN FAMILY Express, no say> wall> communication impossible > hurt > don’t know	
133	Feeling strange		
134	“Wall” between family members		
135	“Open” VS. communication impossible		
136	“Reconciliation” with people	L BELIEF AS A CHRISTIAN	
137	“Reconciliation” between people		
138	“No say”	M HURT IN FAMILY	
139	Express > conflict		
140	Withdraw > hurt		

141	Visitation	N USEFUL ELEMENT IN CPT Self > group > breakthrough	
142	Group sharing		
143	Verbatim discussion		
144	“Seeking help in the group”		
145	“Don’t know”		
146	“Reflecting”		
147	“Different other’s perspectives”		
148	Diploma VS. Pastoral Training	O STRUGGLE OF A CHRISTIAN NURSE Seeking > struggle & complicating > trouble	
149	Other recognition VS. self-understanding		
150	F.T. Chaplain VS. low pay		
151	P.T. Nurse VS. high pay		
152	Serve God VS. Daily need in life		
153	Caregiving as nurse VS. as chaplain		
154	“Seeking God’s will”		
155	“Complicated” to understand		
156	“Trouble”		
157	“Difficult to translate”	P XINLING 157-167	Xinling lingxing same 1) Different in translation 2)everybody has 3) if can related to spirit
158	“Deep in the heart”		
159	“May or may not be”		
160	“Probably difficult to be understood”		
161	“Difficult to express”		
162	“Hard to be touched”		
163	“Emotional related”		
164	“Thought”		
165	“leading to religious beliefs”		
166	Not sure		
167	“Ling, spirit related”		
	“Everybody has”		
168	“Xinling lingxing are the same”		
169	Related to the creator	Q LINGXING	Difference creator
170	Seeking the creator		
171	“Connecting further”		
172	“Further a bit, deeper a bit”		
173	“Difference in whether can connect deep enough”		
174	“Just listen to understand the needs”	H CPT EXPERIENCE Xinling care Care> faith > sharing deeper	
175	“Just care the care”		
176	“Patient Raising the faith topics”		
177	Faith VS Daily life		

178	Faith VS meaning		
179	“Harder to care deeply if no religious faith”	Q LINGXING	
180	“Based on deeper relationships”		
181	“Holy spirit leading me”	R XINGLING CARE AS CHAPLAIN 181-189 Work of Holy Spirit 180-184	Xinling care Ia Identity Ib Belief Ic Attitude Id value 121 Ie feeling
182	“Holy Spirit is in control”		
183	”Serve in Holy Spirit”		
184	“H.S.Inside me”		
185	“Jesus’ representative”		
186	“Not on my own”		
187	“Sees Jesus” through me	Belief 185-188,194	
188	Shows acceptance		
189	Compassion to the patient		
190	“I may not be allowed”	A DIFFICULTY IN NURSING PRACTICE	
191	Not free enough		
192	“Feeling of being loved”	K XINGLING CARE Attitude	
193	Experience of love		
194	“I am a Christian”	S IDENTITY 194-197	
195	“Praying for God’s presence”		
196	“God’s channel”		
197	Relationship with God VS Role		
198	“About the relationship of God and me”	I XINGLING CARE 198-203,206	
199	Care to “serve”		
200	Feeling of “Being seen”		
201	“Praying for in heart”		
202	“Being recognized”		
203	“Moved” in the caregiver and cared		
204	“God’s participation”		
205	“Heart”	Ie Feeling of caregiver 205-206	
206	“Satisfied”		